A STUDY ON REGULATORY FRAMEWORKS AND OPERATION OF COUNSELING CLINICS IN NAIROBI, KENYA

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I Stephen Wahome do hereby declare that this is my original work and that it has not been presented for the award of any degree to any other university.

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DEDICATION

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LIST OF ABBREVIATION

- **ACA** – American Counseling Association
- **AG**- Attorney General
- **AIDS**- Acquired Immunodeficiency Syndrome
- **APA**- American Psychological Association
- **BDI**- Beck Depression Index
- **CAGE-** Cut annoyed guilty and eye opener
- **CASES**-Counselor Activity Self-Efficacy Scale
- **CBO**- Community Based Organization
- **CBT**- Cognitive Behavior Therapy
- **CCPA**- Canadian Counseling and Psychotherapy Association
- **CEI**- Counselor Evaluation Inventory
- **DSM** – Diagnostic and Statistical Manual for mental disorders
- **HIV**- Human Immunodeficiency Virus
- **KAPC** Kenya Association of Professional Counselors
- **KCA**- Kenya Counselors Association
- **KCPA** - Kenya Counselors and Psychologist Association
- **KPyA-** Kenya Psychological Association
- **MOHEST**- Ministry of Higher Education Science and Technology
- **MSE-** Mental State Examination
- **NACADA**- Nation Campaign Against Drug abuse Authority
- **NASCOP**- National Aids Control Program
- **NBCC**- National Board for Certified Counselors
- **NGO**- Nongovernmental Organization
- **PLWHAS**- People Living with HIV/Aids
- **SDQ –** Social Demographic Questionnaire
- **VCT**- Voluntary Counseling and Testing

DEFINITION OF TERMS

- **Counseling Clinic;** a service center providing mental health services to the public registered by statutory body in Kenya.
- **Counseling services;** provision of helping services by a professionally trained counselor.
- **Counselor;** for purpose of this study, a counselor is a person who has undertaken training in counseling from any government registered institution and who provides counseling.
- **Regulatory framework-** legal or statutory structures governing particular discipline.
- **Accredited counselor-** certified and professionally recognized mental health worker by a national or international certification body.

ABSTRACT

The demand for counseling services in Kenya has been on the increase over the last few years. Counseling is a process whose aim is to help clients make better choices by understanding themselves and focusing to change specific aspect of their feeling, thinking and acting. The provision of counseling service by competent persons and clear guidelines on its operations are important in ensuring ethical standards and quality service delivery. The objective of this study was to establish how counseling clinics operate in Nairobi, the qualification and accreditation levels of counseling providers, the type of counseling services provided, efficacy and challenges faced by counselors in the provision of their services. The study design was cross – sectional descriptive survey conducted in Nairobi. The study sample was obtained from counseling clinics operating in Nairobi that are registered by statutory body in Kenya. It was estimated that there were 80 counseling service providers operating in Nairobi that are registered at the Attorney General Chambers (AG), government ministries, and from the counseling/psychological associations. The researcher sampled all of them. The Data collection instruments involved a questionnaire encompassing socio demographic questionnaire (SDQ), a general questionnaire on operations and schedule for counselors, and Counselor Activity Self-Efficacy Scale (CASES). The CASES measures the perceived abilities of counselors in various clinically related activities and skills such as listening, self disclosure and immediacy to the counselors' beliefs about their ability to perform counseling-related behaviors or to negotiate particular clinical situations. The collected data was analyzed using the statistical package for social scientists program (SPSS) version 20. The study found out that counseling providers in Nairobi operate without licenses and there is no legal body to regulate or accredit counselors. Most counselors were good at the use of general counseling skills but there was a significant difference between young and older counselors and the counseling methods used by counselors. The study recommended that there is need for regulated counseling services and a body to enforce ethical compliance and standards. There is need for a minimum level of training and experience for one to be allowed to practices as counselor. There was no significant difference in confidence levels between counselors who are members of a professional body and those that are not. The study recommends further research to establish effectiveness of professional counseling bodies in relations to supervision of counselors and maintenance of best practices.

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Chapter one

1.0 INTRODUCTION

The concept of counseling has been around for ages and it reflects the need for one person to seek out help or advice from another person. Counseling is the process of helping a person understand his or her own problem and seek for solution. It is said to be the first source of help for many people when faced with life challenges. Often, the counselor is seen as a "problem solver" who through direct advice or non-directive guide help client make rational decisions and deal with distressful situations (McReynolds Paul, 1987).

The aim of counseling is to help clients make better choices by understanding themselves and focusing to change specific aspect of their feeling, thinking and acting" (Jones Richard Nelson, 2000). Counseling is designed to help people understand and clarify their views, learn how to reach their self-determined goals through meaningful, well-informed choices, and through the resolution of emotional or interpersonal problem. By listening attentively and patiently, the counselor can begin to perceive the difficulties from the client's point of view and help the client see things more clearly, possibly from a different perspective (Gladding Samuel, 1988).

In Kenya, Counseling has become a popular treatment for a number of social and mental health conditions. The onset of HIV/AIDS pandemic in 1980s has witnessed increased counseling activities and trainings in Kenya and particularly Nairobi. Many people are now practicing "counseling" after undertaking various counseling trainings. The counseling awareness among Kenyans has also gone up and number of client's turning up for counseling services increased (Manono G, Menya P, Rachier C, & Gikundi E, 2002). The demand for counseling training is also on the rise and new counseling institutions have been established to provide the requisite counseling training. This demand for counseling services in Kenya has led to an influx of many providers including *Para-counselors* who lack adequate training and experience to provide effective therapy to their clients.

Although counseling has been practiced throughout many cultures in the past it has only become formally recognized as a profession for just over a century ago. Counseling and psychotherapy become generally accessible to the general public in the post-second world war era (Cushman Phillip, 1995). Since then, the number of counseling approaches has increased and there are numerous counseling providers with diverse training and orientations. This diverse training and application of principles of counseling stimulates interest on the need to understand how counseling is offered.

The term counseling is also applied less specifically to other kinds of brief therapy with limited objectives in which the therapist takes a more active role. According Michael G. Gelder (1989),

counseling is a form of brief psychotherapy and specifically refers to methods developed by Carl Roger's where the therapist takes a passive role. "Largely restricting his/her intervention to comments on the emotional significance of the client's utterance, Rogers believed that this limited procedure, together with the relationship between patient and therapist was *therapeutic* (Gelder, 1989).

Counseling takes place when a *counselor* sees a client in a private and confidential setting to explore a difficulty the client is having, distress one may be experiencing or perhaps dissatisfaction with life, or loss of sense of direction and purpose. As a talking therapy, counseling is seen as "assisting another person to find a solution to his problem through discussion" (Mwamwenda S. Tuntufye, 1996). It is a learning-oriented process, which occurs usually in an interactive relationship, with the aim of helping a person learn more about the self, and to use such understanding to enable the person to become an effective member of society (Kanfer, FH & Goldstein A.P, 1986).

1.1 Background information

The provision of mental health services is critical to human development. There is no health care without appropriate mental health services. Counseling is one of the techniques of providing mental health services. It is regarded as the practical application of psychological principles and therapies. "It is a psychological process that helps deal with human behavior, cognitive processes and common mental health challenges". Counseling is concerned with "normal' problems, role functioning with choices to be made and with actions to be taken. "It focuses on present events, than with past events and on conscious-rational thinking than unconscious functioning," (Kanfer & Goldstein, 1986).

Counseling is a process of *helping* an individual gain insight to their problems and better their lives. According to Nelson-Jones Richard, (2011) the word ***"helper"*** refers more to those using counseling and helping skills as part of their job. Kanfer & Goldstein (1986) states three main difference between professional and informal helper; First, professional helper is *unilateral,* in that the focus of the relationship is in solving the problem of the client. Second, the relationship between the helper and client is formal and confined to specific times and place. Third, it is time limited with the relationship terminated when the stated goals and objectives have been reached. The professional helper or counsellor is often of a *free-for-services* nature and suitably *trained and qualified,* (Kanfer & Goldstein, 1986).

People in all societies, and at all times, have experienced behavior problems. In each culture, there have been well established ways and methods of helping individuals deal with their problems. In traditional African societies, counsel was provided in various forms, the most

common being giving **advice** and **sharing wisdom.** Giving advice has been a common way of providing help for other people. The advice offered was frequently instrumental in helping people to consider their future. In many instances, the extended family was the main source of advice for girls and boys. There was usually no shortage of people willing to share their wisdom with others and giving advice often promoted the dependence of the young person on the advice given. Sharing Wisdom (through proverbs or folk stories) generally refers to experience and knowledge about life and using them judiciously. It was considered the responsibility of elders to provide wisdom or counsel to young persons. The wisdom provided by elderly men and women was part of the counseling function of the family, *(United Nations Educational Scientific and Cultural Organization, (UNESCO), 1997).*

The social mechanism in African family setting made it possible for elders and opinion leaders, priests and teachers among others to provide counsel. This social mechanism is no longer working as people migrate to urban areas and struggle for economic survival. This takes centre stage resulting in weakening of societal structure. The most outstanding examples are: a gradual shift from the extended to nuclear family unit, or single parent family unit; a heavy reliance on a cash economy in poor countries, political demands and expectations. Others are rapid rate of urbanization, high unemployment rate compounded by a high illiteracy rate, a high population growth rate, which leads to large classes in schools; the infiltration of foreign culture through films, television, internet, videos, live performances, and magazines; wars, political instability and epidemics. All these lead to increased numbers of orphans and refugees, and moral decay due to elements from within and outside *(UNESCO, 1997).*

In response to the growing demand for counseling services to deal with the changing societal structures, the guidance, counseling and youth development programs were initiated in Africa in April 1994, following the first Pan African conference on the education of girls that was held in Ouagadougou in 1993. The Pan African conference was designed to introduce or strengthen guidance and counseling in African countries. In Kenya, the first Conference on Guidance, Counseling and Youth Development was held on 22nd to 26th April 2002 in Nairobi, and aimed to bring together counselors in Africa to share their experiences.

1.2 Factors that make people seek counseling services

There are many reasons that make people seek counseling services. Leading among them are depression, stress and anxiety. Others are career issues, marital problems; work related concerns, alcohol and drug abuse, parenting, bereavement, trauma, school and lifestyle diseases, HIV/Aids and terminal illness. Mental distress is the most common reason that drives people to seek counseling services.

Mental illness is an extremely common form of distress, and every disorder can be a miserable, life disrupting experience. In Britain, a survey done in year 2000 showed that 16.6% of the British population is affected by a life disrupting mental illness at any one time. About 25% of people in UK are likely to suffer from a mental disorder at the same time. Mixed anxiety and depression is experienced by 9.2% of adults in Britain, followed by general anxiety at 4.7% and depression (without the symptoms of anxiety) at 2.8%. The least common disorder according to this survey is panic disorder, affecting 0.7% of the population of Britain. The study identified sleep disorders and fatigue as most often reported symptom by those having mental distress, (*ONS, 2000).*

1.3 Problem statement

Counseling has become one of the ways of responding to mental and social health challenges facing Kenyans. As an essential health service, it's important to have providers with appropriate knowledge and skills that would make them effective and helpful to their clients. Clients seeking counseling services deserve true value of what they want from competent personnel who have appropriate training and their operations meet required ethical standards.

Kenya has no regulating body for provision of counseling services. A bill to regulate counseling/psychological services was tabled in Parliament four years ago but is yet to be debated. The counseling associations have tried to bring the counselors together and regulate them through membership enrollment but with limited success. The associations have no legal mechanism to enforce certain ethical standards among its membership or non members.

It's apparent that no authoritative study has been conducted in the past to find out *who* provides counseling services in Kenya, their qualifications, licensing procedures, therapeutic approach used, assessment procedures and types of clients or ailments they treat and the challenges faced by counselors. Lack of such crucial information leaves the provision of this vital service unbridled and exposes the clients/counselors to quality and ethical challenges. It is against this background that it is necessary to investigate the regulatory frameworks and operation of counseling clinics in Kenya.

1.4 Objectives of this study

The broad objective of this study was to understand how counseling clinics operate in Nairobi. The specific objectives were;

1. To establish the procedures and regulations of operating counseling clinic in Nairobi
2. Establish the qualification and accreditation levels of counseling providers
3. Establish the type of counseling methods provided in these clinics
4. Establish the operational challenges faced by the counseling providers

1.5 Justification of this study

The current counseling demand has made many Kenyans seek counseling services from all types of counseling providers. At workplace, some employers have established programs that address the psychological needs of their employees while the government, non-governmental organization, churches, companies, colleges and private practitioners are all involved in responding to these challenges. There is also renewed interest in training workplace peer counselors to tackle the twin problem of HIV/Aids, alcohol and substance abuse among staff.

In the light of increasing number of counseling service providers in Nairobi, this study was necessary to help understand the type of counseling clinics, institutions and personnel offering such services and whether those clinics have certain framework for their establishment. It was also crucial to establish the qualifications levels of counseling providers and the kind of services they provide. This information was necessary for identifying gaps and challenges existing in this industry.

This study is useful in a number of ways;
It has provided useful feedback on the state of counseling services in Nairobi.
The study is useful to professional associations dealing with counselors and relevant government agencies who would like to use the findings to influence policy formulations to enhance counseling services in Kenya.
The findings of this study has provided essential information on the quality of care being provided and sets ground for further research in this area.

1.6 Research questions

The research question was; "*How do counseling clinics operate in Nairobi and what are the qualification levels of personnel manning these clinics?* To address this issue, the following questions had to be answered;
Which are the organizations or clinics that provide counseling services in Nairobi?
What is the registration or licensing procedures for operating these clinics?
Do the counseling providers in these clinics belong to any professional body?
How are these clinics and counseling providers regulated?
What are the qualification levels of personnel operating these clinics?
What types of tests or therapeutic approaches do counselors often use in Nairobi?
What type of relationship, networking and referral systems exists between these providers and other care givers or agencies e.g. hospitals?
What challenges do counselor's face in providing their services in Nairobi?
What type of counseling do they provide?

1.7 Scope of this study

Nairobi was identified as the centre of this study due to its size as urban centre. It has the highest number of counseling providers and counselor-training institutions in Kenya. Records from the Registrar General's office show that there are over eighty counseling centers in Nairobi more than in any other urban centre in Kenya. The study was conducted in the eight districts of Nairobi County.

1.8 Study assumptions of the problem

The assumption was that counseling services are available in major towns in Kenya but there was uncertainty over the quality of services offered. This study assumed that the personnel manning these facilities in Nairobi were "qualified" and capable of giving an accurate view of their services, and they would cooperate in this research. Another assumption was that there were counselors who are not registered and do not offer counseling or others that could be offering counseling but are not registered.

Chapter Two

LITERATURE REVIEW

2.0 THEORETICAL BACKGROUND

The scientific learning of behavior began with the study of human and animal perception under the influence of such men as Wilhelm Wundt, the founder of modern scientific psychology. The application of psychological knowledge and skills started when the principles of animal and human perception were first applied in the field of education by Lightner Witmer: the first person to inaugurate psychological clinic in 1896, (McReynolds, 1987).

This initial skill application grew and expanded its clinical applications to the treatment of various mental health disorders. In early 20th century, counseling became popular and a number of theoretical approaches came into being. Those credited with counseling includes Sigmund Freud, Carl Rogers and Aron Beck among others. Freud was employed as a neurologist and whilst still training he worked with patients who were deemed hysterical. He developed a method of working with hysterical patients which he called *'psychoanalysis'* that focus on the dynamics of the relationships between different parts of the psyche and the external world; thus the term 'psychodynamics' (McReynolds, 1987).

Much as psychological therapies trace their history back to the contributions of Freud, many modern approaches to counseling are now more firmly grounded in other bodies of thought. A separate strand of psychological therapies developed later on the influence of psychology and learning theory under leading thinkers such as B.F. Skinner. Rejecting the notion of 'hidden' aspects of the psyche which cannot be examined empirically, (such as Freud's 'unconscious'), practitioners in the behavioral tradition began to focus on what could actually be observed in the outside world. Finally, under the influence of Adler and Otto Rank *a 'third way'* called **'Client-centered'** was pioneered by the US Psychologist Carl Rogers. Rogers's approach focused on the experience of the person, neither adopting elaborate and empirically un-testable theoretical constructs of the type common in psychodynamic traditions, nor neglecting internal world of the client in the way of early behaviorists. It was largely in response to the US prejudice against lay therapists that Carl Rogers adopted the word *'counseling'*, originally used by social activist Frank Parsons in 1908. Rogers himself became renowned as one of the most influential empirical scientists in the fields of psychology and psychiatry, introducing rigorous scientific methods to psychology and psychotherapy that psychoanalysts themselves had long resisted, (Sexton, T. L., Schofield, T. L., & Whiston, S. C. 1997)

2.1 COUNSELING THEORIES AND THERAPEUTIC APPROACH

There are various models of counseling approach, each with its own theoretical basis. Differences in counseling approach can relate to the individual practitioner's interests, training, the setting in which the counseling consultation takes place, or the predominant client group. Counselors working in particular fields (e.g. relationship guidance, addiction, sexual abuse or health) tend to specialize in the models most used in those areas. When examining specific treatment approaches and efficacy studies there seems to be some evidence of variability in success rates. For example, Panic disorder treatment has been shown to be most successful when cognitive-behavioral interventions are used (Barlow, Craske, Cerny & Klosko, 1989). Such research has led to empirically supported treatments which are often put into a manual format for treatment. Manualized treatments have been developed for numerous conditions such as phobias, anxiety, personality disorders, depression, post-traumatic stress disorder, panic, borderline personality disorder, and substance abuse among others.

2.1:2 Psychoanalytic and psychodynamic therapy

Psychoanalysis was developed by Sigmund Freud in 1896 and focuses on an individual's unconscious, deep-rooted thoughts that often stem from childhood. The treatment principles of **psychoanalysis** largely focus on the **unconscious** functioning, and seek to discover how unconscious thoughts affect current behavior and thoughts. The Psychodynamic therapy focuses on the use of analyzing the individual's unconscious thoughts, free association and catharsis, interpretation of dream analysis, transference and resistance techniques.

2.1:3 Behavioral therapy

Behavioral therapy (developed in 1953) is associated with Ivan Pavlov and B.F skinner, Joseph Wolpe and Hans Eysenck. It focuses on an individual's learnt or conditioned behavior and how this can be changed. It uses principle of learning to reduce or eliminate maladaptive behavior. The approach assumes that behavior is learned and can be unlearned through conditioning, reinforcement and systematic desensitization. This therapy is useful for dealing with issues such as phobias or addictions (Simons J, Kalichman S & Santrock J, 1994)

2.1:4 Cognitive therapy

Cognitive therapy deals with thoughts and perceptions, and how these can affect feelings and behavior. It was popularized by Edward Thorndike with cognitive psychology research in 1935. By reassessing negative thoughts patterns, the individual can learn more flexible, positive ways of thinking, which ultimately affect their feelings and behavior towards those thoughts.

2.1:5 Rational-emotive therapy (RET)

Founded in 1955, the therapy is based on Albert Ellis' assertions that individuals become psychologically disturbed because of their beliefs, especially those that are irrational and self defeating. At the centre of these hypotheses is the concept that events do not force people to have emotional-behavioral reactions. It is rather their interpretation or thoughts about events that precipitate emotion and behavior. The therapy targets to challenge those thoughts, attitudes, beliefs and meanings which create emotional-behavioral disturbance, (Ellis Albert & Dryden Windy, 1997),

2.1:6 Cognitive behavior therapy (CBT)

Cognitive Behavioral Therapy (CBT) was expounded by Aaron Beck in 1960 and combines cognitive and behavioral therapies. Behavioral therapy is based on the way one thinks (cognitive) and/or act. This therapy recognizes that it is possible to change and recondition our thoughts or behavior to overcome specific problems. The approach focuses on thoughts, altitudes, emotions, physical feelings and behavior. CBT puts emphasizes on the effects of our thoughts on behavior and behavior change techniques. It is useful in dealing with a number of conditions including depression, anxiety and phobias, (Simon et al. 1994).

2.1:7 Humanistic therapies:

Humanistic therapy emerged in early 1950's and is associated with Carl Rogers and Abraham Maslow. Although behavioral therapy and psychoanalytic methods were available, a humanistic approach offered individuals another alternative. Humanistic therapies focus on self-development, growth and responsibility. It recognizes human capabilities in areas such as creativity, personal growth and choice. The main goal of humanistic therapy is to find out how individuals perceive themselves, recognize growth, self-direction and responsibilities. Humanistic therapies have three main approaches;

2.1:7 Client centered approach; Carl Rogers is associated with client-centered counseling, having devoted his entire professional life to the practice, teaching, research, and refinement of this approach. The person-centered approach is still one of the most important popular humanistic counseling approaches which perceive human beings as having an innate tendency to develop towards their full potential. The counselor or psychotherapist in this approach aims to provide an environment in which the client does not feel under threat or judged. This enables the client to experience and accept more of who they are as a person, and reconnect with their own values and sense of self-worth. Person-Centered Counseling focuses on an individual's self-worth and values. Being valued as a person, without being judged, can help an individual to accept who they are, and reconnect with themselves, (Nelson-Jones, 2011).

2.1:8 Gestalt approach: Gestalt therapy focuses on the individual's experience, including their thoughts, feelings and actions, and concentrates on self-awareness in the *'here and now'* (what is happening from one moment to the next). Roughly translated from German, Gestalt means 'whole' and was developed in the 1940's by Fritz Perls. The main goal of this approach is to make the individual more aware of the self taking into account their mind, body and soul.

2.1:9 Transactional analyses; Transactional Analysis is based on the theory that each person has three ego states: Parent, Adult and Child. By recognizing these ego-states, Transactional Analysis attempts to identify how individuals communicate, and how this can be changed to provide opportunities for individuals to change repetitive patterns that limit their potential. Transactional Analysis was developed during the late 1950's by psychiatrist Eric Berne and seeks to identify what goes wrong in communication and allows clients to trust their decisions and think or act as an individual improving the way they feel about themselves.

2.1:10 Transpersonal psychology and psycho-synthesis; Transpersonal Psychology means beyond the personal and seeks to discover the person who transcends an individual's body, age, appearance, culture etc. Transpersonal therapy literally means "beyond the personal" and involves encouraging the individual to discover the deep core of who they really are, (the real person that transcends an individual's body, age, gender, physical space, culture, appearance etc.) It involves building on an individual's qualities, their spirituality and self development. It was developed by psychiatrist Roberto Assagioli in 1960s and involves an integration of the psychological and transpersonal elements, (Firman John & Gila Anne, 2002).

2.1:11 Trans-theoretical model of behavior change: It was development by James Prochaska and colleagues at University of Rhodes Island in 1977. It focuses on individual's readiness to act on a new healthier behavior, and provides strategies to guide the individual through the stages of behavior change to Action and Maintenance of the new behavior. The therapy recognizes that behavior change does not happen in one step; rather people tend to progress through different stages at their own rate, on their way to successful change. The model has been applied to a broad range of behaviors including addiction issues, family, self-harming behaviors, weight loss, etc, (Prochaska J.O & DiClemente C, 1984)

2.1:12 Solution focused brief therapy (**SFBT**): It is attributed to works of Steve de Shazer & Insoo Kim Berg, and is often referred to as 'solution focused therapy' or 'brief therapy', It is a type of talking therapy that is based upon social constructionist philosophy. It focuses on what clients want to achieve through therapy rather than on the problem(s) that made them seek help. The approach does not focus on the past, but instead, focuses on the present and future (Guterman, J.T 2006).

2.2 RESEARCH IN COUNSELING AND PSYCHOTHERAPY

The word counseling and psychotherapy has been inter-changeably used in most literature. Examining the progress and outcome of clients undergoing therapy, it is apparent that while the majority of clients improve, a minority remains unchanged, and still others actually deteriorate (Lambert & Cattani-Thompson, 1997). The effectiveness of counseling has been examined in several studies and has been shown to be generally effective. In analyses of data from patients who were followed up, research has shown that counseled patients are significantly more likely to have recovered than non-counseled patients (Woolfe Ray, Dryden Windy, & Sheelagh Strawbridge, 2003).

The degree to which counseling has been shown to be effective varies greatly with the methodology being utilized, but overall the success and satisfaction rates seem to consistently remain very good (Hemmings Adrian, 2000). Hemmings conducted a meta-analysis of client outcomes in the United Kingdom and out of 26 reports, 17 included a measure of client satisfaction. His work demonstrated that the number of participants who rated counseling as helpful to very helpful ranged from 88% (Clwyd, 1996) and 75% (Baker et al. 1998) down to 66% (Gordon, 1995). Hemmings examined the study of Kingston & Richmond (1997) where over half gave counseling the maximum rating for helpfulness and it was noted that the high ratings were not dependent on the counselor, and there were no significant differences between practices. One study examined by Hemmings found levels of client satisfaction reported at 93% in East Kent (Bunker & Locke, 1998). A survey of empirical data by Lambert's, (1992) indicate that therapeutic change is around 40% due to client and extra-therapeutic variables, 30% due to relationship factors, 15% due to expectancy and hope factors, and 15% due to the techniques and models of individual approaches (Lambert & Cattani-Thompson, 1997).

The purpose of conducting research into an activity like counseling or psychotherapy is to enhance knowledge, to enable us know more about the way counseling and psychotherapy operate and how or why they are effective (or not effective). According to Jerome Bruner, (2002) there are two distinct ways of knowing; *paradigmatic* (associated with positivist physical sciences and involves the establishment of abstracts) and *narrative* (that is associated with everyday account of human actions, usually in form of stories. Paradigmatic knowledge reflects an “objective” deterministic world while narrative knowing reflects a “constructed” world in which human agency can make things happen. Both method of knowing are necessary and has the potential to make a significant and necessary contribution to the evidence base for counseling and psychotherapy (Mcleod John, 2011).

Research into the outcome of psychotherapy is hugely important because clients and health care managers and other groups of people are vitally interested in knowing “what works”. For

most of quantitative studies carried out over the years, most of them have yielded a puzzling experience finding –the *equivalence paradox* (Cooper Mike, 2008). Research indicates that different types of therapeutic interventions, when compared with each other in a fair test appear to have same level of success. A study done in Sweden by Thomas Wilson et al. (2007) produced findings that seem to explain why equivalence paradox exists and what it means. They interviewed clients who had received CBT or psychodynamic therapy and observed that clients reported different outcomes from different types of therapy (Cooper, 2008).

On the characteristic of good therapists, there are a small number of therapists who are markedly more effective than their colleagues. Skovholt & Jennings, (2004) asked therapist in the regions in which they worked to nominate those colleagues they found to be "*the best of the best*"- therapist to whom they would refer close friends and family members. Skovholt & Jennings, (2004) then identified a set of "*Master therapist"* each of whom has been nominated by several colleagues, and invited them to take part in an in-depth interview that explored all aspects of their careers and approach to their therapeutic work. What they found out was that these *master therapists* were voracious learners and read widely around all therapy approaches. Though they (master therapists) described themselves as working within a specific therapeutic approach (e.g. CBT, Family therapy etc) they were endlessly curious about human condition. Another recurring theme was that master therapists were open to receiving feedback in the relationship and using this information to guide their own personal development. The entire master therapists in the study were in the private practice, (Mcleod, 2011).

A strong alliance between the counselor and the client has been associated with client treatment participation. Connors et al. (1997) analyzed rating of the therapeutic working across 75 counselors-clients dyads over the course of 12 weeks of treatment. Research showed that working alliance, whether assessed by the client or therapist significantly predicated treatment participation by the client. Additionally, counselor's emotional responses during treatment are associated with client retention and client perception of the therapy relationship. Negative feeling, anger and anxiety displayed by therapist were associated with fewer clients returning for follow-up treatment, (Milmoe et al. 1967). The quality of the relationship which the client can establish with the counselor probably heads the list of factors influencing therapeutic outcome, and the client's judgment of this relationship probably carries the most (Lamberts M.J. 1992)

While no one type of therapy stands out in terms of overall effectiveness, however, individual counselors clearly do. Within given therapeutic approaches, research shows very significant variation between individual counselors. Indeed, the evidence suggests that the abilities of individual therapists may be a more significant factor in determining outcome than therapeutic

orientation! So there may not be a clear answer to the question of whether there are better or worse therapeutic orientations, but there certainly are better and worse therapists (Skovholt & Jennings, 2004).

Developing a more comprehensive understanding of the therapeutic relationship in counseling plays a crucial role in the quality of client-therapist connection. In a study carried out by (Rob, Bedi, et al. 2005), therapy clients were asked to describe incidences in their therapy that has contributed to the strengthening of their relationship. Some mentioned kindness; when therapists introduced a technique this showed he/she cared about their clients; the way therapist dressed and how the room was furnished helped to make a good connection with the therapist. The underlying theme in many of these incidences was that clients wanted to know that the therapist actively cared about them; (Muran Christopher & Barber Jacques, 2010).

In another study, Constance Dalenberg, (2004) asked clients who had been angry with their therapist about what they had wanted from their therapist at that point and what they felt about what had actually been offered. What these clients said was that they felt hurt and even angrier when the therapist retreated behind a professional mask in response to their anger and felt able to begin to make sense of their feelings if the therapists acknowledged their own role in what had happened. Care and emotional honest themes were found in a similar study by (Thomas Wilson et al. 2007).

On the failure to overcome cultural barriers in counseling, two studies done by (Thompson, et al. 2004; & Ward, 2005), African-Americans participants reported that they believed counseling could potentially be valuable for them but observed that therapist were insensitive to the African-American experiences, and that therapy services were generally not accessible to members of their communities.

2.3 DEVELOPMENT IN COUNSELING

Counseling theories and practice therapy has been shaped by cultural and economic factors over the years. Phillip Cushman, (1990, 1995) examined the social and cultural factors that has shaped the evolution of therapy and its rise to prominence. Cushman observed that the "self is socially constructed", and that social mobility, consumerism, and other cultural aspects of early twentieth century capitalism resulted in the development of an "empty" self that was filled by consumer goods and therapeutic exploration of "inner frontiers", (Cushman, 1995).

It is important to understand that cultural issues and indigenous knowledge has not remained static. For example, (Peltzer Karl, 2002) identified the following three distinctive categories of

people living in sub-Sahara Africa. The *traditional* persons who are little affected by modernization and functioning within the framework of their culture; the *transitional* persons who move between two cultures that is the traditional culture and contemporary, industrial and postindustrial worlds with regard to their daily activities and the *modern* person who fully participates in the activities of the contemporary industrial and post-industrial world. The definition and nature of indigenous knowledge shows it changes over time to deal with demand of ever-changing sociopolitical context having impact on counseling and research practices, (Elias Mpofu, 2011).

Counseling research in African setting must take cognizance of cultural relevance, cultural sensitivity and cultural appropriateness across all decisions relevant to the selected theories, techniques, strategies, interventions and methods associated with counseling and research (Mpofu, 2011). The role of oral tradition can play in the healing process of people of Africa ancestry who have lost the senses of connectedness to a past that provides succor in a variety of cultural contexts and traditional structures. African indigenous healing is deeply rooted in the physical, emotional and spiritual aspects of being and inexplicably linked on to religious belief system. It seeks to provide health, sanity, spiritual solace and other family and community collective values (Edward & Edwards, 2009).

The scope of counseling should be broad based to include full spectrum of diversity (Savickas, M.L 2003). The quest is for an approach that "enables rather than fits and this clearly imply exploitation of the oral tradition in counseling especially with clients of African ancestry (Watson et al. 2009). Research in counseling in African contexts shows there need for counselor to enhance their understanding and knowledge of indigenous form of healing, indigenous healing practices, and the healers who provide these methods of healing. It would also be beneficial to investigate how both western and African ways of healing could be integrated to provide optimum psychological services (Mpofu, 2012).

2.4 CLINICAL MENTAL HEALTH COUNSELING

Counseling is one of the applied methods of psychology often practiced by mental health workers such as social workers, counselors, psychologist and psychiatrist and is based upon a number of theoretical approaches. Clinical mental health counselors are highly-skilled professionals who provide flexible, consumer-oriented therapy. They combine traditional psychotherapy with a practical, problem-solving approach that creates a dynamic and efficient path for change and problem resolution (Mpofu, 2012).

According to Psychotherapy & Counseling federation of Australia *(PACFA),* Clinical mental health counselors work within a clearly contracted, principled relationship that enables

individuals to obtain assistance in exploring and resolving issues of interpersonal, intra-psychic, or personal nature. They offer a full range of services including: Assessment and diagnosis, Psychotherapy, Treatment planning and utilization review, Brief and solution-focused therapy, Alcoholism and substance abuse treatment, Psycho-educational and prevention, and Crisis management (PACFA, 2012).

The Profession of counseling and psychotherapy requires people who can be able to provide clear diagnosis and treatment. The most commonly used diagnostic tool is the Diagnostic and Statistical Manual for mental disorders (DSM IV).
It comprises five Multi-Axial evaluation areas;
Axis 1: Deals with Psychopathology; examines the underlying psychological disorder, differential diagnosis and co-morbidity
Axis II: Examines presence of Developmental, Personality disorders or mental retardation
Axis III: General medical conditions or Physical disorder present in addition to the psychopathology
Axis IV: *Psychosocial/ Environmental Stressors,* Life stressors; positive and negative events in life. Paykel E.S, (1976) ranked some of the causes of depression being life events such as loss of family, employment, marriage, etc)
Axis V: Global Assessment of Function (GAF); examines functioning and safety in the three major areas; Social, Occupational & Psychological functioning based on a continuum of mental health and illness using 100 point scale (100 – highest level of functioning)* GAF may be used to predict the prognosis of the treatment.

2.5 ASSESSMENT OF COUNSELOR PERFORMANCE

The Assessment of counselor performance is frequently discussed in professional counseling literature, yet it remains a topic that includes numerous significant issues and few points of agreement. The need for assessing counselor performance is evident for several reasons; counseling usually helps people but also can harm them, for example, through inappropriate counselor-client pairings or through counselor incompetence. Counselor performance assessment is necessary to facilitate good counselor-client matches and/or to remedy incompetence. Assessment of counselor performance thus is inextricably linked to and is needed for protection of the public's welfare, (Bleuer Jeanne, 1984).

The need for assessment of counselor performance also relates to the counseling profession itself. A profession evolves positively only when its members continue to improve their functioning. According Dorn & Jereb, (1985) such development in the counseling profession depends upon having effective methods of evaluating common and innovative ways of

functioning. Counselor performance assessment thus has the potential to improve the counseling profession, (Dale Johnson, 2010)

The assessment of counselor performance includes both subjective and objective processes, with the former far more common. Subjective evaluations of counselor performance include the use of rating forms, judgments of counselors' actual counseling activities, and global judgments by supervisors. Instruments for assessing counselor performance range from highly subjective instruments that often are quickly created and at best have some degree of face validity, to those that have measurable, empirically established psychometric properties. Two of the latter have found particular favor in the counseling profession-the Counselor Evaluation Inventory and the Counselor Rating Form. Each has been shown to be effective for evaluating counselor performance. Rating forms have the definite advantage of being structured, efficient means of gathering assessment data, (Biersner, Bunde, Doucette, & Culwell, 1981).

The most recent trend in assessment of counselor performance has been to broaden the perspective on what it means to be an effective counselor, that is, to acknowledge that there is more to being a good counselor than just counseling skill and training. Assessments within this perspective encompass both actual counseling performance and other activities in which professional counselors engage. Assessments in the latter regard typically address activities such as diagnosis, case management, treatment planning, consultation, professional development, research, materials development, and inter-professional communication (Bell, 1990). The Counselor Activity Self-Efficacy Scale (CASES) measures the perceived abilities of clinicians in various clinically related activities and skills such as listening, self disclosure and immediacy to the counselors' beliefs about their ability to perform counseling-related behaviors or to negotiate particular clinical situations. The CASES consist of three broad counseling activity domain; performing basic helping skills, managing session's tasks, and negotiating challenging counseling situation and presenting issues (Lent, Hill, & Hoffman 2003

Three general areas related to effective counselor performance have been investigated. The first is counselor characteristics, the study of which is based on the belief that "good" counselors have unique and identifiable personal characteristics, and that if identified, those characteristics can be used as counselor trainee selection criteria. The second area is counselor communication skills. Verbal communication skills have been examined far more than nonverbal skills, but both are important components of effective counselor performance. Since communication is at the heart of counseling, assessment of counselors' communication skills is a primary means of assessing counselor performance. Third is counselor certification and licensure intended to protect the public's welfare. Possession of an academic degree in a counseling specialty is one common credentialing criterion, but academic credentials do not

necessarily indicate counseling competence. Effective assessment of counselor performance is needed in counselor credentialing processes, (Lent et al, 2003).

2.6 COUNSELOR ACTIVITY SELF-EFFICACY SCALES

Counseling psychology and related helping professions have long been engaged in efforts to understand and promote the process of counselor development. "The counselor self-efficacy refers to counselors' beliefs about their ability to perform counseling-related behaviors or to negotiate particular clinical situations". There are six factors and three sub-domains: Insight Skills, Exploration Skills, Action Skills (under sub-domain of Helping Skill Self-Efficacy), Session Management Self-Efficacy (factor/sub-domain), Relationship Conflict, and Client Distress (under sub-domain of Counseling Challenges Self-Efficacy).

According to Lent et al, (2003) the **counselor Activity Self-Efficacy Scales (CASES)** was developed to assess self-efficacy for performing helping skills, managing the counseling process, and handling challenging counseling situations," (Lent et al, 2003). The CASES scale has been used in previous studies; Goodyear & Guzzardo, (2000) while using the CASES tool found that supervision positively impacts on counselor performance with clients. There is predictive relationship between mindfulness and key counselor training outcomes, particularly the ability to pay attention in the counseling sessions and counseling self-efficacy.

Sample items in the scale; examines the following factors in counseling

Exploration skills; contains 5 items that reflects on communication competency, restatement, use of open questions and reflecting feelings (asking questions that help clients to clarify or explore their thoughts or feelings).
Insight Skills; Has 6 items that reflects on the clinicians perceived abilities to challenges clients inconsistency, offer interpretation, and use immediacy statements.
Session Management; contains 10 items to facilitate process of therapy; Self-Efficacy, helping client to understand his or her thoughts, feelings, and actions.
Action Skills; Has 4 items on Information sharing (teach or provide the client with data, opinions, facts, resources, assignments or answers to questions)
Relationship Conflict; Has 10 items on interpersonal tensions; negative reactions toward (e.g., boredom, annoyance).
Client Distress; Has 6 items on difficult presenting problems, recent experience on traumatic life event (e.g., physical or psychological injury or abuse)

Respondents respond to the 31 items using a 9-point Likert-type scale that ranges from 0-9(0=no confidence at all, 9=complete confidence). Each CASES subscale self efficacy index is

calculated individually by dividing the total of the individual items scales scores and dividing by the number of items for that subscale with indexes ranging 0 to 9.

2.7 COUNSELING ASSESSMENT TOOLS AND TESTING

Although the published literature on testing has increased, proper test utilization remains a problematic area. The issue is not so much whether a counselor uses tests in counseling practice, but when and to what end tests will be used (Corey Gerald & Callanan Patrick, 1984).

Counselors use tests generally for assessment, placement, and guidance, as well as to assist clients to increase their self-knowledge, practice decision making, and acquire new behaviors. Information used includes the gathering of data on clients, assessing the level of some trait, such as stress and anxiety, or measuring clients' personality types. The purpose of non-informational tests is to stimulate further or more in-depth interaction with the client. Steps involved in the process of using tests in counseling include the following: Selecting the test, administering, scoring, interpreting the results, and communicating the results (Anastasi, Anne, 1988; Cronbach, 1979).

2.8 COUNSELING PROVIDERS

In the African perceptive counseling was seen as an advice or counsel given by an expert or elder, but in the current perspective which is more driven from the west, counseling is a helping profession whose members are specially trained, licensed and certificated to perform a unique and needed service to fellow human beings of their society. For a counselor to meet the standard expected of him, the following qualities are necessary; self awareness, honesty, congruence, ability to communicate and knowledge in their field, (Gladding, 1992).

2.9 QUALIFICATION AND ACCREDITATION

What qualifications does one require to become a counsellor and be accredited? The answer to this question may differ across countries and regions. In some countries, counseling is a recognized profession regulated by different legislations and accredited National state bodies.

In the US, a number of states usually allow individuals to practice *counseling* with a license and have different categories of counseling providers namely; Licensed counselors, Psychiatrist, Psychiatric nurses, psychiatric technicians, social workers, marriage and family therapist and psychologists. There are, however, settings in which a person with any degrees might work as a “counselor” or “psychotherapist” without a license: Drug and alcohol counselors and residential treatment counselors, who work for large agencies, or in hospitals, are examples. A validly ordained Catholic priest who is actively serving his Ordinary (bishop) can practice counseling

as a part of his pastoral functions. Some Protestant ministers and Rabbis can also provide counseling within the context of their religious duties. In this case, "counselor" is a job title, not a license to practice independently, (Peterson & Nisenholz, 1987).

In Britain and America one cannot practice counseling without a degree and some certification from a recognized professional body. In the US, the American Association of State Counseling Boards (AASCB) is an organization of state boards that regulate the practice of counseling while the National Board for Certified Counselors (NBCC) deals with credentialing counselors who meet certain standards. In California, Licensed Professional Counselor must be holds of a master's or doctoral degree in counseling or a counseling-related field from an accredited college or university. According to Peterson & Nisenholz, (1987), a licensed professional counselor should obtain either a masters or doctorate degree in counseling in order to practice.

In Canada the counseling profession is not regulated by a statutory process except in the provinces of Quebec, Ontario, and Nova Scotia. In 1986, the Canadian Counseling and Psychotherapy Association (CCPA) established a credentialing service for its members: Canadian Certified Counselors (CCC): a National Certification Program for Professional Counselors. The counselor certification is a national service that identifies to the public those counselors who CCPA recognizes as qualified to provide counseling services in Canada. Obtaining the status of Canadian Certified Counsellor (CCC) includes recognition of standards of professional preparation, continuing education, and a formal code of ethics. As a self-regulating body, CCPA provides advice and discipline for certified members on matters of professional conduct.

In Kenya, anyone with counseling training can provide counseling but the level of intervention and skill may differ across the board. Some counselors operate from own private clinics, faith based organizations, hospitals, schools, community organization and others from the confines of their homes. To distinguish between a professionally qualified trained counselor and those who have done short trainings is often difficult.

2.10 COUNSELING METHODS

Counseling methods are influenced by theoretic approach and schools of thought. The three main schools influencing contemporary individual counseling and psychotherapy practice are the psychodynamic school, the humanistic and the cognitive-behavior school. Sometimes the humanistic school incorporates existential therapeutic approaches to become the humanistic-existential school. A fourth school, the postmodern therapies adopt a *social constructionist* viewpoint, assuming that how people process and construct information about themselves and their world is central to their existence (Nelson-Jones, 2011)

In practice, counselors combine traditional psychotherapy with practical, problem-solving approach that creates a dynamic and efficient path for change and problem resolution. There are seven counseling methods or therapeutic approach commonly used by counselors. They include the classical psychoanalysis of Sigmund Freud, analytical theory of Carl Jung, Person centered therapy of Karl Rogers, Gesltalt therapy of Frits Perls, Cognitive behavior therapy of Aron Beck, the Adrian therapy and the modern solution-focused therapy of Steve de Sharz & Insoo kim Berg. In reality, many counselors and therapists regard themselves as working in either eclectic or integrative ways. Eclecticism is the practice of drawing from different counseling and therapy schools in formulating client problems and implementing treatment interventions. Integration refers to attempting to blend together theoretical concepts and/or practical interventions drawn from different counseling therapy approaches into coherent and integrated whole (Nelson-Jones, 2011))

It is essentially a common sense approach to helping people by tailoring therapy to the needs of the individual client. The role of the therapist is to help the client identify mistaken goals, and to help the client do away with self-centeredness, egotism, and isolation, and to develop positive, meaningful interpersonal relationships. According to Nelson Jones (2011) counselors should read more primary and secondary sources, have continuous development programs, evaluate their theoretical approach and undergo personal therapy to develop self-awareness and reflective skills.

2.11 CHALLENGES FACED BY COUNSELORS

There are various challenges that counselors face in the provision of their services. Some of these challenges include;

Professional development; This comprises lack of measures to develop (personal growth) to become better counselors. How to regain and maintain resilience, openness, tolerance, empathy, motivation, compassion and ongoing commitment as counselors living in a world of rapid social and technological changes remains a challenge.

Service delivery issues; Counselors should develop and maintain a *treatment frame*work - those conditions necessary to support a professional relationship or treatment frame, set by many mental health professionals (Briere, 1989)

Recognizing professional limitations counseling professionals should reconcile a conflict between traditional beliefs and practices taught to them as children and new social thinking. Some challenges such as transference, counter transference, secondary trauma and burn out remain a challenge to the profession. Burnout occurs when the pressures of work erode a counselor's spirit and outlook and begin to interfere with his/her personal life (De Bellis, 1997).

Ethical behaviors; This involves determining the ethically appropriate course of action in a given situation; rejecting contact outside the therapy session, observing professional ethics and establishing and enforcing a clear policy in regard to payment of services.

Regulatory framework; Lack of regulations and laws governing counseling services exposes both the counselor and clients to legal and ethical challenges. The weak enforcement of ethical standards and lack of acceptable accreditation system contributes to poor professional development.

Marketing services; Marketing is a venue which could help establish counselors in the public consciousness so that a multitude of other publics become counselor advocates and articulate that professional counselors are skilled deliverers of services. Lack of proper marketing strategies and stigma of mental health hamper the growth of counseling services.
Another major challenge is encouraging people to seek counseling services. For example, in the United Kingdom, it is common for people to seek informal support from friends and family around their career choices and to bypass career professionals altogether, (Galassi, J.P., Crace, R.K., Martin, G.A., James, R.M. & Wallace, R.L, 1992).

2.12 LICENSING

Licenses in counseling in a number of countries are governed by various laws and regulated by different bodies. In America, National Board for Certified Counselors (NBCC) certification program recognizes counselors who have met predetermined standards in their training, experience and performance on the National Counselor Examination for Licensure and Certification (Butler L. & Crago M. 1991).

Psychiatrists by virtue of their license to practice medicine can perform psychotherapy with proper training from a psychoanalytic institute while a *Psychiatric Nurse* can perform psychotherapy with proper training in some settings, but not independently! A Social Worker who has a master's degree in social work (MSW) can become a Licensed Clinical Social Worker (LCSW) and practice independently as a psychotherapist while a person who has received a master's degree in clinical psychology may be licensed as a Marriage and Family Therapist.

According to Brooks D.K & Weikel W.J (1996) a licensed clinical mental health counselor has met or exceeded the following professional qualifications:
Earned a master's degree in counseling or a closely related mental health discipline;
Completed a minimum of two years post-master's clinical work under the supervision of a licensed or certified mental health professional and Passed a state-developed or national licensure or certification examination

According to a report, "*Mental Health, United States, 2004*" published by the U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA), more than 100,500 mental health counselors are licensed or certified for independent practice in the United States.

Kenya has not yet developed any licensing procedures as the industry is still young and there are no legislations regulating it. This vacuum has created mushrooming of many counseling outfits and it is not uncommon for counselors and psychotherapists to attempt to treat problems for which they have not been specifically—or adequately—trained for.

2.13 COUNSELING TRAINING

In Kenya, counseling training is provided by a number of Universities, colleges and middle level institutions that address various needs. The curriculum for these institutions, period of training and degrees offered is equally varied. There is no regulated national curriculum followd by local training institutions. Many psychology training institutions offer degrees, in *Counseling Psychology*; a branch of psychology specifically concerned with the practice of counseling. Though counseling programs usually teach various theories of psychotherapy, training and supervision, the practice of psychotherapy usually is not part of the education for counseling (Nelson-Jones, 2011).

2.14. LEGAL AND REGULATORY FRAMEWORK

Regulatory framework has been found to impact positively on service provision. In New south Wales, *Psychological and Counseling services regulatory frame work (2009*) consultation paper, indicated that the implementation of a regulatory framework for psychologists and counselors providing treatment and counseling services in the New South Wales workers compensation system was a positive step towards improving the quality and consistency of services provided to injured workers and employers of injured workers with a psychological injury.

The overall objective of the legal and regulatory policy is to ensure that the needs and concerns of clients and patients are safeguarded even in the context of health care such as counseling.
According to Wango G.M (2011), there are some statutes that can be applied in professional counseling practice in the context of existing legal and justice system in Kenya. Theses statutes are scattered in various legislations and do not deal with profession counseling. Kenya has experienced a period of policy positioning in line with the new constitution that encompasses democratic changes, health and human rights. These broad positions will impact on both public and private sector to improve quality and increase efficiency to transform the lives of people in all aspect.

The profession of counseling in Kenya like everywhere in the world must operate within existing legal and regulatory framework. The counselor has a responsibility to practice in a professional manner within the ethical guidelines established by the profession within the law. According Corey & Callahan (1984), “focus of acceptance of personal responsibility does not imply we can do anything we want. We need to recognize the social, environmental, cultural and biological realities that limit our freedom of choice. It’s crucial to learn how to cope with the external and internal forces that limit our decision and behavior”.

2.15 PROFESSIONAL BODIES AND ASSOCIATIONS

The counseling profession, in general, “is as strong as its weakest links. And, its weakest links are the masses of counseling professionals all over the world who reference themselves as 'just' counselors--who don't understand the power of belonging to and banding together through professional organizations-who don't recognize the need for lobbying for appropriate legislation for each and every one of the specialties--who see their 'jobs' as just paychecks--and who fail to see or project the sense of professionalism and commitment required for the discipline to survive” (O'Bryant & Beverly, 1992).

Professional bodies regulate activities of certain professions and help maintain ethical standards. In America, National Board for Certified Counselors (NBCC) and American Counseling Association (ACA) work together to further the profession of counseling in America. NBCC focuses on promoting quality counseling through certification and advances professional accountability and visibility. It promotes professional counseling to private and government organizations and ensures a national standard developed by counselors. National certification can be a continuing source of career enhancement and pride for counseling professional.

2.16 SUMMARY OF LITERATURE REVIEW

Overall, no one therapeutic approach stands out as offering better results than the other. While theories are essential and provide a foundation for counseling, evidence-based practice has the opportunity to move the profession of counseling out of its theoretical boxes and historical beliefs into an era of integrated practice in which counselors use the best available science combined with clinical experience to successfully help a wide variety of clients. Evidence-based practices can provide a source of clinical knowledge that can increase a counselor's effectiveness with clients, become a basis of professional education and counselor development, and serve as a unifying force for the profession that will set the agenda for the next evolution of counseling.

There is benefit for a regulated service both for counselors and consumers. The advantage includes setting standards and ensuring ethical procedures. It helps in career development for counseling providers and is a tool for the profession to protect their rights and those of their clients. It is apparent that an accreditation and regulating body is what we need in Kenya but there is need for a system that will help nurture the growing counseling profession in Kenya, and which responds to the unique situation of counseling services in Kenya.

2.17 CRITIQUE OF THE THEORIES

The outcome research evidence has repeatedly found that theoretical orientation is not a major factor in the outcome of counseling (Sexton et al. 1997). Some counselors or psychotherapists practice a form of '*integrative*' therapy, which means they draw on and blend specific types of techniques. Other practitioners work in an '*eclectic*' way, which means they take elements of several different models and combine them when working with clients. Most counselors prefer to use different therapeutic orientations or combined approach to deal with specific problems presented by their clients.

The theory alone is unlikely to make counseling effective. Instead, some research points to a set of "common factors" that seems to be part of effective counseling regardless of counselor, client, or theoretical orientation. While the theories provide different approach towards understanding human behavior, the use of Empirically Supported Treatments (EST) protocols developed for individual and family problems seem to be gaining a lot of prominences and point the way for the future of counseling, providing a glimpse into evidence-based counseling practice, (Sexton et al. 1997).

While specific theoretical models do not seem important to positive outcomes, evidence-based counseling intervention protocols are differentially effective with the client problems they were developed to help. What do seem to be important counselor contributions to effective counseling is the level of *skillfulness* (defined as competence rather than experience), *cognitive complexity* (ability to think diversely and complexly about cases), and ability to *relate and relationally* match with the clients with whom they are working. In addition, it is essential that counselors have the knowledge and ability to assess the presenting "problems" of the client so they can identify the appropriate evidence-based protocols and competently apply those protocols in order to increase the likelihood of successful intervention, (Sexton et al. 1997).

Chapter Three

METHODOLOGY

3.1 Study design

This was a cross-sectional descriptive study.

3.2 Study Area and Population size description

This study was conducted in Nairobi. According to the 2009 census, Nairobi has a population of 3.4 million people who live in its area of 684km2, representing almost 9% of the Kenya's population. Nairobi has the highest number of counseling service providers and training institutions making it an ideal centre for this study.

3.3 Sample size determination

Availed records from the AG chambers and government ministries revealed that there were about eighty (80) registered counseling clinics in Nairobi. All these clinics were targeted for this study.

3.4 Inclusion and Exclusion Criteria;

The study focused on the clinics operating in Nairobi County. For inclusion into this study the counseling service providers should have been registered by a statutory government body and provided counseling services within the city's jurisdiction. In addition, the selected sample had to consent to the inclusion in the research study. Those who refused to consent or were operating outside Nairobi County were excluded from the study

3.5 Sampling method;

The study sample was obtained from counseling clinics operating in Nairobi that are registered by a statutory body in Kenya. A list of these counseling clinics/institutions in Nairobi was complied to form the study sample. Details of the clinic were sourced from AG chambers, ministries, Nairobi city council and counseling/psychological association. Their telephone contacts were sourced from the local telephone directories and internet.

3.6 Data collection Procedure

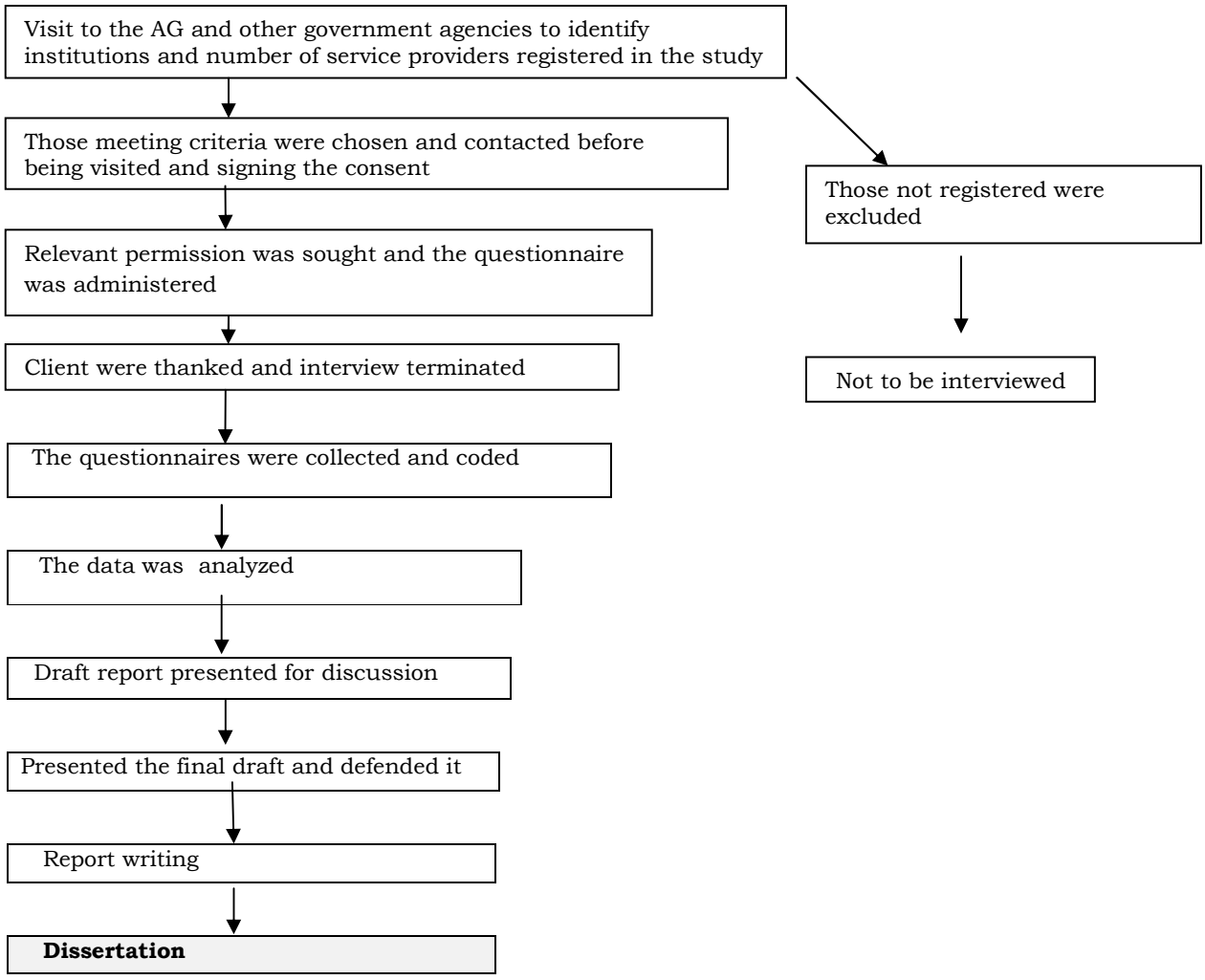
Data collection was carried out through physical visits to counseling clinics. The counseling institutions in Nairobi identified as study sample were visited in all the constituencies in Nairobi and the counseling providers were interviewed and filled the questionnaire. Where there was more than one counseling clinic in an institution or more than one counselor, the

subjects were selected using a simple random selection interval of every old number in a predetermine numbering of each clinic or counselor. The researcher collected and kept all the questionnaires.

3.7 Data collection Instruments

The data collection instruments included a socio demographic questionnaire: a general questionnaire on operations of counseling services, an interview schedule for counselors and Counselor Activity Self-Efficacy Scale. The counselor self-efficacy refers to counselors' beliefs about their ability to perform counseling-related behaviors or to negotiate particular clinical situations. The questionnaire is annexed as appendix No 2

3.8 Data collection flow chart



3.9 Data management

The research tool was administered by the researcher and data collected put together for cleaning and coding. Data cleansing was undertaken by cross checking to detect syntax errors and remove irrelevant or invalid record from the dataset. Maintenance of cleansed data was observed to avoid re-cleansing especially on values that have remained constant. Descriptive statistical method of data analysis was applied using frequency distributions, measure of central tendency (mean, median and mode), and graphs which describe the data.

3.10 Data Analysis and Interpretation

The data collected was analyzed using the statistical package for social scientist (SPSS) version 20. The results are availed in graphs, bar charts, standard deviation and reporting narratives.

3.11 Ethical consideration

Permission was sort from University of Nairobi/Kenyatta National Hospital Ethics and Research committee to carry out this research. Those participating in this research were assured of confidentiality and fully informed of what they were getting into and their consent sort through signing the consent form (*a consent form is hereby attached as appendix 1*). The information received was treated confidentially and names of those sampled protected. The right to privacy or not to answer the questions was respected.

3.12 Delimitation

This study focused on the centers offering counseling services within geographical area of Nairobi County and those that agreed to participate in the study.

3.13 Budget and Time schedule

	ACTIVITY	**Month (2012)**	**Amount KSHS**
1	Proposal development	July 2012	20,000
2	Defense of the proposal	October 2012	-
3	Ethical approvals	November 2012 to April 2013	-
4	Data collection	May to June 2013	70,000
5	Data analysis report writings	June 2013	60,000
6	Discussion with supervisors	July 2013	-
7	Miscellaneous	July	40,000
8	Result presentation	July 2013	
	Total		**190,000**

Chapter 4

FINDINGS

4.0 INTRODUCTION

Data collection was successfully obtained from 76 counseling providers out of the targeted 80 representing a 95% response rate that was found adequate for this study. A total of 87 institutions were visited but eleven (11) institutions did not fill the questions; 6 had relocated to other locality that could not be traced through contact either in the internet or from AG registrar's office, 3 completely declined to fill out the questionnaire and two confirmed they had closed their centre's due to lack of business or other commitments.

Participated	declined	Had relocated	Closed down	Total visited
76	3	6	2	87

4.1.0 SOCIAL DEMOGRAPHIC CHARACTERISTICS

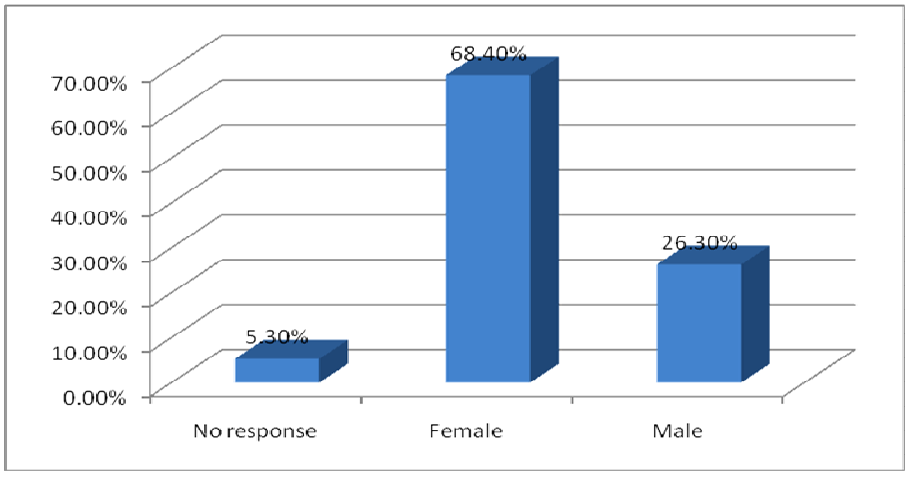
AGE; Most of the counselors sampled 34 (44.7%) were aged between 31-40 years with only 3.9% aged 50 years and above.

Table 1

		N	%
Age category	No response	10	13.2%
	20-30 years	11	14.5%
	31-40 years	34	44.7%
	41-50 years	18	23.7%
	over 50 years	3	3.9%
	Total	76	100

4.1.1 Sex identity

Figure 1



The number of female counselors is more than male counselor as shown above. The male-female ration1; 2.6

4.1:2 Marital status

Most counselors 44 (57.9%) are married, 19 (25%) are single while 9.2% are separated.

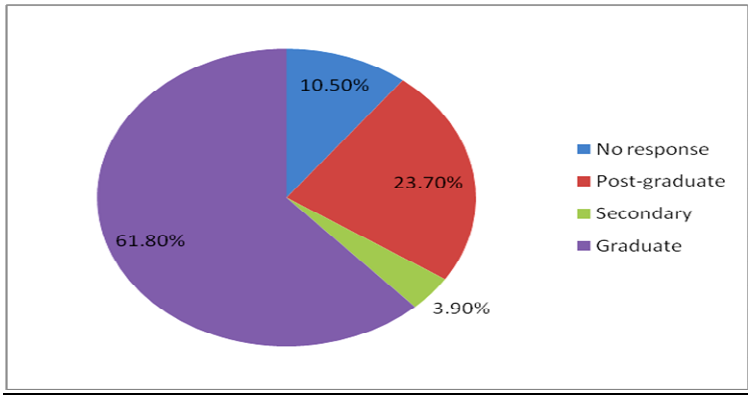
Table 2

Marital status	No responses	5	6.6%
	Divorced	1	1.3%
	Married	44	57.9%
	Separated	7	9.2%
	Single	19	25.0%
		76	100

4.1:3 Education levels (Academic)

Majority of the counselors 47 (61.8%) hold graduate level education, 18 (23.7%) postgraduate, 3 (3.9%) secondary level education while 8 (10.5%) didn't respond to the question.

Figure 2



4.1:4 Employment status

Most of the counselors 43 (56.6%), are on full time employment while 11 (14.5%) are self employed.

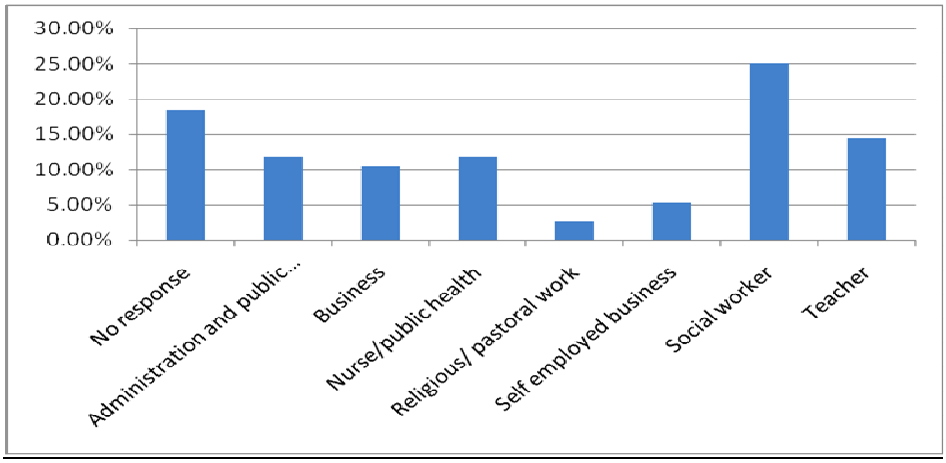
Table 3

Employment	No response	19	25.0%
	Employed	43	56.6%
	Self-employed	11	14.5%
	Volunteers	3	3.9%
	Total	76	100%

4.1:5 previous professional backgrounds of the counselors

According to the graph below social workers accounts for 19 (25%) followed by teachers at 14.5% and nurses at 12.5% respectively

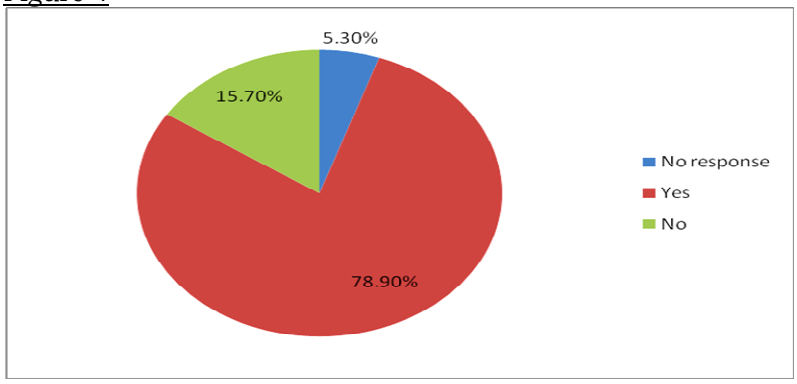
Figure 3



4.1:6 counseling as the primary job

Most counselors 60 (78.9%) practice counseling as their main activity while 12 (15.7%) have other activities on the side.

Figure 4



4.1:7 Type of clients counselors attend to

Majority of counselors 52 (68.4%) attend to all types of clients with only 4 (5.3%) specializing in children alone

Table 4

What type of clients do you attend to	No response	3	3.9%
	Adolescent	6	7.9%
	Children	4	5.3%
	Adults	11	14.5%
	All	52	68.4%
	Total	**76**	**100%**

4.1:8 Client volumes per specific period

It appears there are counselors who are very busy while others are not fully engaged as shown in the table below

Table 5

score	mean	Std deviation	median	Mode	minimum	maximum	Range
Daily	5	3	4	3	2	24	22
Weekly	12	9	10	15	2	36	34
Monthly	31	26	21	40	2	121	119
Quarterly/Term/Semester	95	108	50	50	10	400	390
Annually	344	308	365	12	12	800	788

4.2 QUALIFICATION & ACCREDITATION LEVEL OF COUNSELING PROVIDERS

4.2:1Professional Qualification in counseling

More counselor 36 (47.3%) hold diploma level qualification in counseling as compared to 31 (40.9%) who hold graduate and post graduate qualification in counseling.

Table 6

		N	%
Professional Qualification in counseling	No response	6	7.9%
	Bachelor Degree in counseling	18	23.8%
	Certificate	3	3.9%
	Diploma in counseling	22	28.9%
	Higher Diploma	14	18.4%
	Masters in counseling	12	15.8%
	PhD	1	1.3%
	Total	76	100%

4.2:2 Length of experience and training as a counselor

There was a mean of 5 years work experience and 3 years counseling training

Table 7

Length of experience	Mean	Median	Mode	Minimum	Maximum	Range	Standard Deviation
Years worked	5	5	5	1	20	19	3
Duration of training	3	2	2	1	8	7	1

4.2:3 Institutions that trained them as counselors

There are various institutes that provide counseling training but Amani Counseling and Training Institute, one of the oldest training centre lead with 16 (21%). Out of the training institutions identified by the counselors 13 (98.8%) are private institutions.

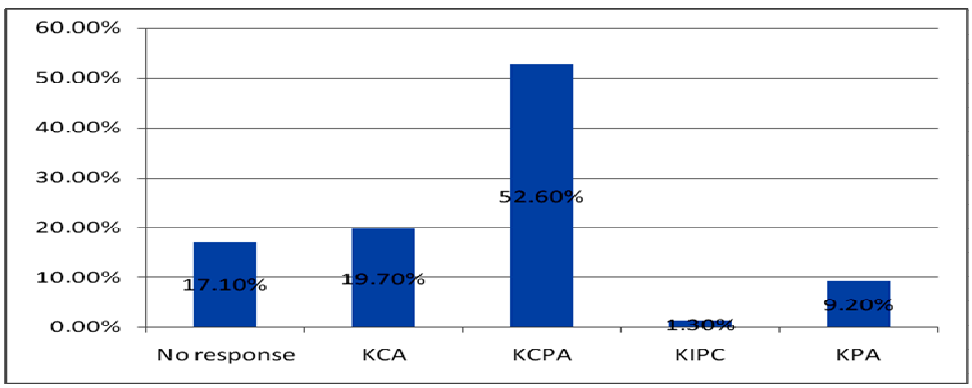
Table 8

Training institution		n	%
Institution that offered the counseling training	No response	8	10.5%
	Amani counseling and training institute	16	21%
	Catholic University of East Africa	2	2.6%
	Daystar University	4	5.2%
	Embulmbul centre	6	7.9%
	Kenya Association of Professional Counselors	2	2.6%
	Kenya institute of development studies	1	1.3%
	Kenya Institute of Professional Counselors	5	6.6%
	Kenyatta University	9	11.8%
	Maranatha college	9	11.8%
	Methodist University/ Community concern institution.	1	1.3%
	Nairobi university	3	3.9%
	Nyeri pastoral centre	1	1.3%
	Pyongyong university	1	1.3%
	SAPTA centre	3	3.9%
	United states international university (USIU)	5	6.6%
	Total	76	100%

4.2:4 Membership to professional counseling bodies

Most counselors 63 (80%) belong to a professional body; 40 (52.6%) belong to Kenya Counselors and Psychological Association (KCPA), followed by 15(19.7%), Kenya Counselor Association (KCA) and 6 (9.2%) Kenya Psychological Association (KPyA)

Figure 5



4.2:5 Supervision from counselor's professional associations

A good number of counselors 45 (59.2%) indicated they get supervision from their professional association while 23 (30.3%) do not.

Table 9 (a)

Do you receive any supervision from your professional bodies	No response	8	10.5%
	No	23	30.3%
	Yes	45	59.2%
	Total	76	100%

4.2;6 Do you receive any personal counseling supervision?

Most counselors 50 (65.8%) receive personal supervision while 26 (34.2%) do not.

Table 9(b)

Personal supervision / therapy	No	26	34.2%
	Yes	50	65.8%
	Total	76	100%

4.2:7 Who provides the supervision?

The supervision is usually provided by their personal therapist 50 (65.8%). The frequency varies with 20 (26.3%) having it monthly while 35 (46.1%) did not respond to this question.

4.2.8 Did you require a license to operate as counselor?

The table shows many counselors 48 (61.3%) knew they did not require licenses to operate.

Table 10

		n	%
Did you require any type of license to operate as a counselor	No	48	61.3%
	Yes	28	38.7%
	Total	**76**	**100%**

4.2.8.1 If yes where did you get it from and how long did it take

The table below indicates that most of the counselors 53 (69.7%) operate with no license.

Table 11

		N	%
License source	No license	53	69.7%
	City council	3	3.9%
	KAPC	2	2.6%
	KCA	4	5.3%
	KCPA	5	6.6%
	AG (registrar office)	9	11.8%
	Total	**76**	**100%**

4.2:8:2 Period it took to get a license

Table 11(b)

		n	%
Duration of license	No response	58	76.3%
	2-6 months	8	10.5%
	1-2years	10	13.1%
	Total	**76**	**100%**

Majority 58 (76.3%) did not respond to this question consistent with those who did not require license

4.2:9 State the body/institution that accredited you as a counselor

The table below shows that registration at AG chambers was the most common among all counselors at 19 (25**%)** although the body (AG chambers) does not give any accreditation

Table 12

Registering body	N	%
City Council of Nairobi	4	5%
KAPC	2	3%
Kenya Counseling and Psychological Association	11	14%
Ministries of Health	11	14%
MOHEST	3	4%
NACADA	2	3%
NASCOP	1	1%
NGO board	1	1%
AG (Registrar)	19	25%
None	1	1%
Total	76	100

4.3 The type of counseling services provided

A good number of counselors provide General counseling at (26)34.2%.

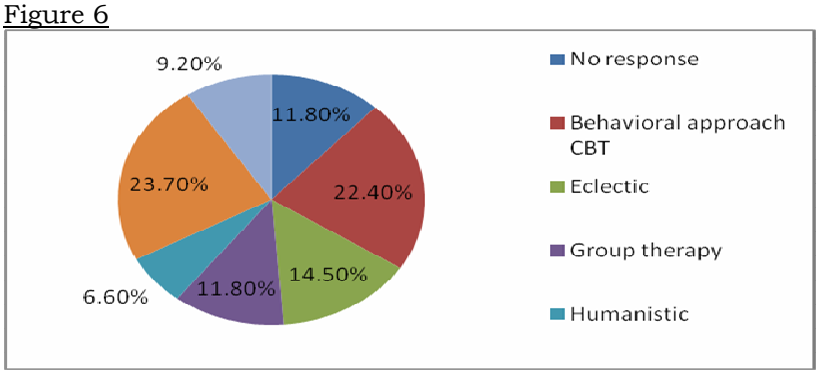
Table13

What type of counseling services do you provide?		n	%
Type of counseling services provided	No response	5	6.6%
	Career/Guidance	5	6.6%
	General counseling	26	34.2%
	HIV/VCT	4	5.3%
	Marriage & family relationships	12	15.8%
	Mental illness	16	21.1%
	Substance abuse	8	10.4%
	Total	76	100%

4. 3.1 Type of counseling method the counselors often use?

The most commonly used method of counseling is personal centered method of Carol Rogers at 23.7% and Cognitive Behavior Therapy (CBT) at 22.4%

Figure 6



4.3.2 Type of psychological test conduct

There were varied responses with personality test at 17 (22.4%) but 23 (30.2%) did not indicate the psychological test they often conduct.

Table 14

		n	%
What type of psychological tests do you conduct	No response	23	30.2
	Addiction test/CAGE	11	14.5%
	Anxiety panic test	5	6.6%
	BDI	4	5.3%
	Hamilton depression scale	7	9.2%
	MSE	7	9.2%
	Neuropsychological Assessment	2	2.6%
	Personality test	17	22.4%
	Total	76	100%

4.3.3 The type of screening tools they use?

The general assessment tool was rated at (28.9%) and was the most preferred followed by self screening tool at 18.4%

Table15

		n	%
What type of screening /testing tools do you use in counseling	No response	22	28.9%
	BDI	4	5.3%
	CAGE	1	1.3%
	General Assessment	22	28.9%
	Psychometrics	3	3.9%
	Questionnaire interview	10	13.2%
	Self screening	14	18.4%
	Total	76	100%

4.3.4 Three most common problems among male and females clients

Parenting issues top the list at 20% among male clients while relationship problems are the leading among female clients at 18%. Drug abuse problems were the most common among both male and female clients at 17% and 16% respectively.

Table16

Males	n	%
Parenting	15	20%
Drug Abuse	13	17%
Financial issues	11	14%

Females	n	%
Relationship issues	14	18%
Drug Abuse	12	16%
Marital fidelity issues	8	11%

4.4 TYPE OF COUNSELING CLINICS OPERATING IN NAIROBI

This study found out that most clinics operating in Nairobi 31 (40%) were privately owned. The rest are owned by Non-Governmental organization 19 (25%), public institutions at 9 (11%), faith based organization 7 (9.25%) and community based organization 6 (7.9%)

Table 17

Type of counseling institution of organization	Private	NGO	Public	Faith based	CBO	others	missing	Total
	31	19	9	7	6	2	2	76
	40.8%	25%	11.8%	9.2%	7.9%	2.6%	2.6%	100%

4.4.1 How long the organization has been in operation

Some counseling institutions 28 (36.8%) have been in existence for 6-10 years, 15 (19.7%) for 16-20 years and 1-5 years respectively, 8 (10.5%) for 11-15 years while 6(7.9) have operated for over 21 years. Averagely, most counseling facilities have been in operation for between 5 to 10 years

Table 18

How long has your organization been in operation	No response	4	5.3%
	1-5 years	15	19.7%
	11-15 years	8	10.5%
	6-10 years	28	36.8%
	16-20 years	15	19.7%
	21 and above	6	7.9%
	Total	76	100%

4.4.2 What services do you provide as a counseling institution?

Averagely, many counseling institutions 50 (65.8%) provide counseling services while others offer different services alongside counseling especially on health 24(31.6%) and education at 13(17%)

Table 19

	No		Yes	
	N	%	n	%
Health	52	68.4%	24	31.6%
Education	63	82.9%	13	17.1%
Social	71	93.4%	5	6.6%
Income generation	75	98.7%	1	1.3%
Gender	71	93.4%	5	6.6%
Religious services	74	97.4%	2	2.6%
Counseling	26	34.2%	50	65.8%
Sensitization	71	93.4%	5	6.6%
HIV and AIDS	63	82.9%	13	17.1%
Youth	69	90.8%	7	9.2%
Women	72	94.7%	4	5.3%
Legal	74	97.4%	2	2.6%
Relief and support	75	98.7%	1	1.3%
Other services	67	88.2%	9	11.8%

4.4.3 Who are your target clients?

Almost all the clinic interviewed 75 (98.7 %) confirmed they offer counseling services. There are different targets of clients among the counseling clinic with adolescent leading the pack at 29%.

Table 20

Target clients	N	%
Adolescent	22	29%
Alcohol and drug abuse clients.	7	9%
All	12	16%
Gender based violence survival	10	13%
General clients.	13	17%
PLWHAS	7	9%
Terminally ill patient/families	1	1%
Total	76	100%

4.4.4 Do you provide counseling training in your institutions?

More than half of the counseling institution 39 (51.3%) offer training on counseling indicating that half of the counseling centres offer twin services of counseling and training

4.4.5 Did you require license or permission to operate a counseling facility?

Eighty-four (84.2%) indicated they required license to operate counseling facility

Table 21

Did you require any license or permission to operate a counseling facility	No response	4	5.3%
	No	8	10.5%
	Yes	64	84.2%
	Total	76	100%

4.4.6 Which body provided the license?

Most counselors 53 (69.7%) operate without licenses. No single body mentioned below seems to have the lead in the provision of license and there was no prerequisite condition required

Table 22

		n	%
source to license to operate counseling services	No license	53	69.7%
	City council	3	3.9%
	KAPC	2	2.6%
	KCA	4	5.3%
	KCPA	5	6.6%
	Registrar General (AG)	9	11.8%
	Total	76	100%

4.4.7 Personnel; How many Counselors provide counseling at your clinic?

The mean for both full time staff and part time was 4 with a mode of 2.

Table 23

	Mean	Median	Mode	Minimum	Maximum
Full time staff	4	3	2	0	20
Part- time staff	4	2	1	1	25
Volunteers	3	2	2	0	17
Student/attachment	2	2	1	1	10

4.4.8 Existence of counseling network

Majority said there was counseling network in their area especially at district level 34 (44.7%), divisional level 15 (19.7%) and national level at 14 (18.4%). However, it wasn't clear how the counselors network together.

4.4.9 Payment for the counseling services

Majority 55 (72.4%) said most of their clients pay for counseling services while 11(14.5%) are paid for by donors and 9(11.8%) by referring agencies. The range of payment differs with many clinics 61(80.3%) charging for their services and 14(18.4%) providing free services. The highest fee charged is 3000-4000 4 (5.3%) and the lowest is 500-1000 15(19.7%).

Table 24

		n	%
What is the range of your consultation fee	No response	1	1.3%
	1000-1500	18	23.7%
	1500-2000	9	11.8%
	2000-2500	11	14.5%
	2500-3000	4	5.3%
	3000-4000	4	5.3%
	500-1000	15	19.7%
	Free/ no fee charge	14	18.4%
	Total	76	100%

4.5 CHALLENGES FACED BY COUNSELORS IN NAIROBI

The challenge faced by many counselors includes inadequate facilities 24(32%) and lack of capacity building programs to enhance counselor's performance 30(39%). Lack of awareness on counseling services by the populace, burnout out and poor remuneration were also identified at 8%, 25% and 6% respectively.

Table 25

Resources Challenges

	n	%
No response	33	43%
Inadequate personnel	6	8%
Low remuneration	6	8%
Inability of clients to pay	8	11%
Inadequate facilities	24	32%
Total	76	100

Professional challenges

	n	%
No comment	18	23.6%
Dual relationship	3	4%
Lack of awareness of counseling services	6	8%
Burn out	19	25%
Capacity building.	30	39%
Total	76	100

4.6 THE COUNSELOR SELF EFFICACY RATING SCALE

4.6.0 Use of General counseling skills; How confident are you that you could use these general counseling skills effectively with most clients over the next week?

Table 26

	Mean	Median	Minimum	Maximum	Standard Deviation
Attending (orient yourself physically towards the client)	8	8	2	9	2
Listening (capture and understand the messages that clients	8	8	2	9	2
Restatements (repeat or rephrase what the client has said	7	8	3	9	2
Open questions (ask questions that help clients to clarify	8	8	4	9	1
Reflection of feelings (repeat or rephrase the client's	7	8	2	9	2
Self-disclosure for exploration (reveal personal	7	8	1	9	2
Intentional silence (use silence to allow clients to get in	7	8	0	9	2
Challenges (point out discrepancies, contradictions defenses,	7	8	3	9	1
Interpretations (make statements that go beyond what the	7	8	2	9	2
Self-disclosures for insight (disclose past experiences	7	8	2	9	2
Immediacy (disclose immediate feelings you have about	7	7	2	9	2
Information-giving (teach or provide the client with	7	8	2	9	2
Direct guidance (give the client suggestions, directives,	7	8	1	9	2
Role-play and behavior rehearsal (assist the client to	7	7	1	9	2
Homework (develop and prescribe therapeutic	8	8	3	9	2

According to table I above, the mean was 7and 8 on the use of general counseling skills indicating complete confidence among the sampled population. The standard deviation was 1 and 2 showing all counselors are across the same range.

On the use of challenging skills (ability to point out discrepancies, contradiction, defenses and bring them to the client's attention) 96% showed complete confidence in the use of this skill. The same was for the use of open questions (asking questions that help clients to clarify or explore their thoughts and feelings) at 94.7%.

The data is further analyzed in the table 27 below to provide the quantity and percentage in table form. According to the CASES tool those scoring 0-2 show no confidence, 2-5 some confidence and 6-9 complete confidences.

How confident are you that you could use these **general counseling** skills effectively with most clients over the next week?

Table 27

	No confidence		**Some confidence**		**Complete confidence**	
	n	%	n	%	n	%
Attending (orient yourself physically towards the client)	0	0.0%	7	9.2%	69	90.8%
Listening (capture and understand the messages that clients communicates	0	0.0%	5	6.6%	71	93.4%
Restatements (repeat or rephrase what the client has said in a way that is succinct, concrete and clear	0	0.0%	6	7.9%	70	92.1%
Open questions (ask questions that help clients to clarify /explore their thoughts or feelings).	0	0.0%	4	5.3%	72	94.7%
Reflection of feelings (repeat or rephrase the client's statement with emphasis on feelings	0	0.0%	5	6.6%	71	93.4%
Self-disclosure for exploration (reveal personal about your history or credentials	1	1.3%	9	11.8%	66	86.8%
Intentional silence (use silence to allow clients to get in touch with their thought or feelings	1	1.3%	8	10.5%	67	88.2%
Challenges (point out discrepancies, contradictions defenses, client is unaware of	0	0.0%	3	3.9%	73	96.1%
Interpretations (make statements that go beyond what the	0	0.0%	7	9.2%	69	90.8%
Self-disclosures for insight (disclose past experiences	0	0.0%	6	7.9%	70	92.1%
Immediacy (disclose immediate feelings you have about	0	0.0%	9	11.8%	67	88.2%
Information-giving (teach or provide the client with	0	0.0%	5	6.6%	71	93.4%
Direct guidance (give the client suggestions, directives,	4	5.6%	6	8.3%	62	86.1%
Role-play and behavior rehearsal (assist the client to	1	1.3%	9	11.8%	66	86.8%
Homework (develop and prescribe therapeutic	0	0.0%	7	9.2%	69	90.8%

Decreases in confidence levels were noted on the use of role play (11.8%), self-disclosure for exploration (11.8) % and use of immediacy at 11.8%.

4.6.1 Use of specific counseling skills

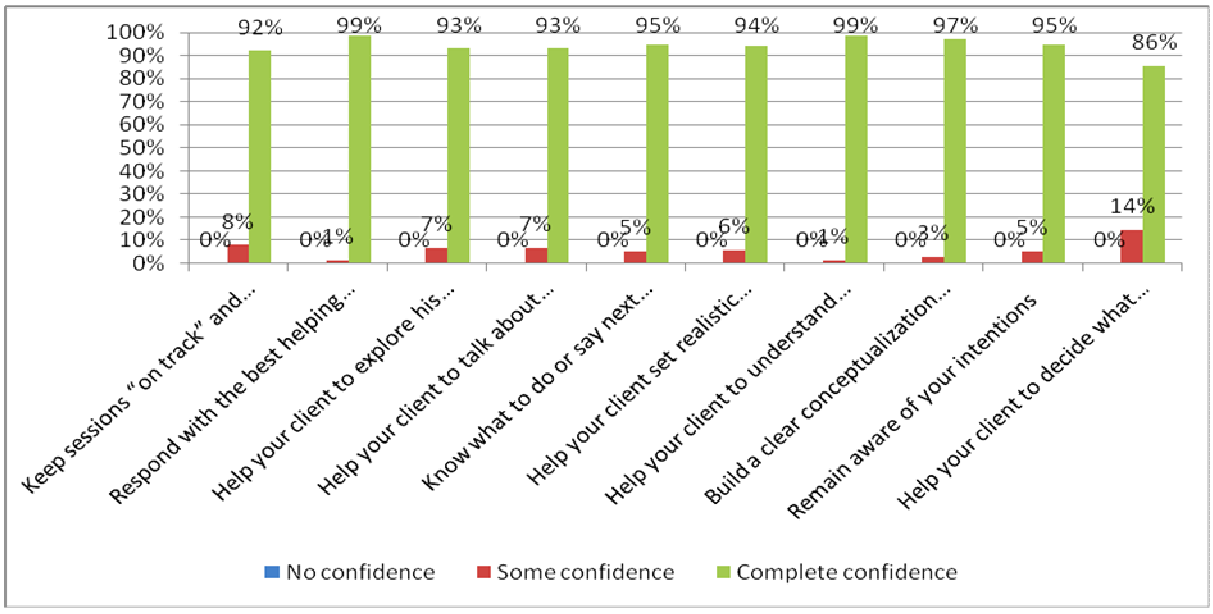
How confident are you that you could do these specific tasks effectively with most clients over the next week?

Table 28

	Mean	Median	Minimum	Maximum	Standard Deviation
Keep sessions "on track" and focused	7	8	2	9	2
Respond with the best helping skill	8	8	3	9	1
Help your client to explore his or her thoughts,	8	8	3	9	1
Help your client to talk about his or her concerns at a "deep"	7	8	3	9	2
Know what to do or say next after your clients talks.	8	8	4	9	1
Help your client set realistic counseling goals.	8	8	3	9	2
Help your client to understand his or her thoughts	8	8	4	9	1
Build a clear conceptualization of your client	8	8	4	9	1
Remain aware of your intentions	8	8	3	9	1
Help your client to decide what actions to take	7	8	2	9	2

The use of specific counseling skills had a mean of 7 and 8 similar general skills. Figure 6 below indicates the percentage.

Figure 7



The counselors scored well on the use of specific skills especially on "*responding with best helping skill*s' scoring 99%. Ninety percent were good in helping clients understand their thoughts and feelings which is the principle aim of counseling. Only 14% did not have complete confidence to help the client decide on their next course of action.

4.6.2. Confidence working with clients with specific condition

How confident are you that you could work effectively over the next week with a client who…

Table 29

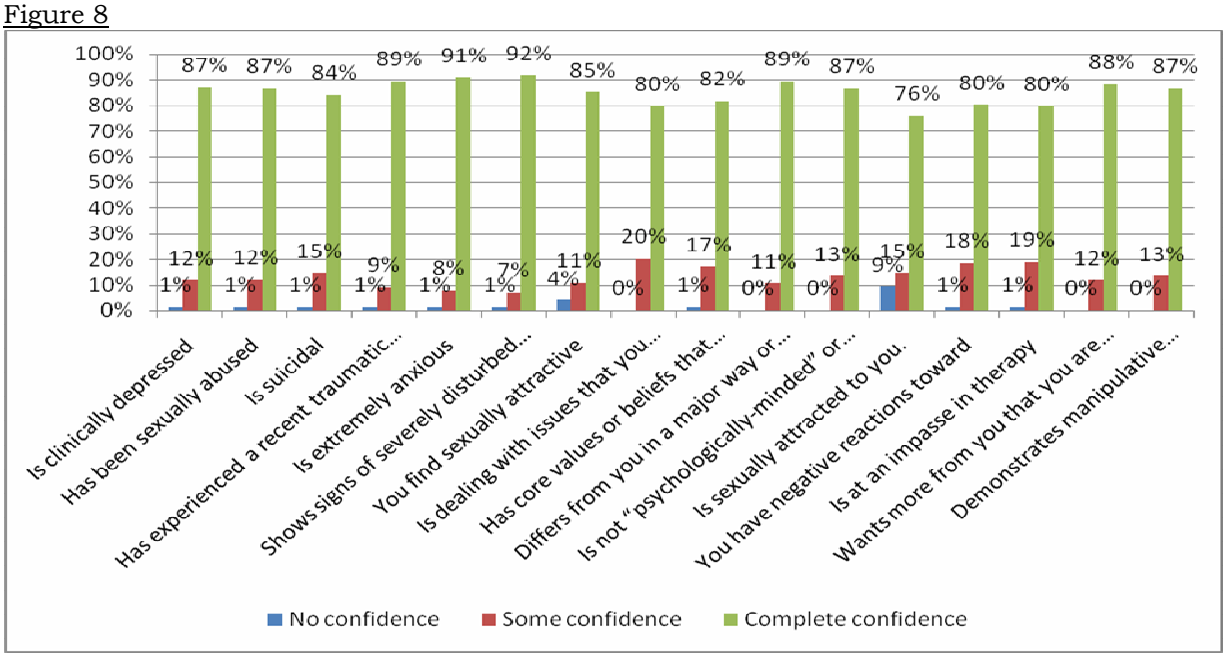
	Mean	Median	Minimum	Maximum	Standard Deviation
Is clinically depressed	7	7	0	9	2
Has been sexually abused	7	8	0	9	2
Is suicidal	7	7	0	9	2
Has experienced a recent traumatic life event	7	8	1	9	2
Is extremely anxious	7	8	1	9	2
Shows signs of severely disturbed thinking	7	8	0	9	2
You find sexually attractive	7	8	1	9	2
Is dealing with issues that you personally find difficult	7	7	2	9	2
Has core values or beliefs that conflict with your own	7	7	1	9	2
Differs from you in a major way or ways	7	8	2	9	2
Is not "psychologically-minded" or introspective	7	7	2	9	2
Is sexually attracted to you.	6	7	0	9	3
You have negative reactions toward	7	7	0	9	2
Is at an impasse in therapy	6	7	1	9	2
Wants more from you that you are willing to give	7	8	2	9	2
Demonstrates manipulative behaviors in-session.	7	8	2	9	2

Some counselors have *no confidence* in dealing with clients with some condition such as clients who are sexually attracted to them at 9.3% and those the counsellor find sexually attracted to at 4.1%.

Table 30

	No confidence		Some confidence		Complete confidence	
	n	%	n	%	N	%
Is clinically depressed	1	1.3%	9	11.8%	66	86.8%
Has been sexually abused	1	1.3%	9	12.0%	65	86.7%
Is suicidal	1	1.3%	11	14.7%	63	84.0%
Has experienced a recent traumatic life event	1	1.3%	7	9.2%	68	89.5%
Is extremely anxious	1	1.3%	6	7.9%	69	90.8%
Shows signs of severely disturbed thinking	1	1.4%	5	6.9%	66	91.7%
You find sexually attractive	3	4.1%	8	10.8%	63	85.1%
Is dealing with issues that you personally find difficult	0	0.0%	15	20.3%	59	79.7%
Has core values or beliefs that conflict with your own	1	1.3%	13	17.1%	62	81.6%
Differs from you in a major way or ways	0	0.0%	8	10.5%	68	89.5%
Is not "psychologically-minded" or introspective	0	0.0%	10	13.3%	65	86.7%
Is sexually attracted to you.	7	9.3%	11	14.7%	57	76.0%
You have negative reactions toward	1	1.3%	14	18.4%	61	80.3%
Is at an impasse in therapy	1	1.4%	14	18.9%	59	79.7%
Wants more from you that you are willing to give	0	0.0%	9	11.8%	67	88.2%
Demonstrates manipulative behaviors in-session.	0	0.0%	10	13.3%	65	86.7%

Figure 8



4.7 SDQ VS COUNSELLOR ACTIVITY SELF EFFICACY SCALE (CASES)

4.7.1 Age of the counselor

Table 31

CASES Confidence level Vs Age		N	Mean	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum	P value
					Lower Bound	Upper Bound			
Part 1 mean score	20-30 years	11	2.867	.1193	2.787	2.947	2.7	3.0	0.379
	31-40 years	32	2.921	.1272	2.875	2.967	2.6	3.0	
	41-50 years	18	2.941	.0994	2.891	2.990	2.7	3.0	
	over 50 years	2	2.967	.0471	2.543	3.390	2.9	3.0	
	Total	63	2.919	.1176	2.889	2.948	2.6	3.0	
Part 2 mean score	20-30 years	10	2.850	.1841	2.718	2.982	2.6	3.0	0.013
	31-40 years	31	2.974	.0893	2.941	3.007	2.6	3.0	
	41-50 years	17	2.971	.0772	2.931	3.010	2.7	3.0	
	over 50 years	3	3.000	.0000	3.000	3.000	3.0	3.0	
	Total	61	2.954	.1134	2.925	2.983	2.6	3.0	
Part 3 mean score	20-30 years	7	2.857	.2000	2.672	3.042	2.5	3.0	0.979
	31-40 years	29	2.875	.1744	2.809	2.941	2.5	3.0	
	41-50 years	18	2.872	.1812	2.781	2.962	2.4	3.0	
	over 50 years	3	2.833	.0955	2.596	3.070	2.8	2.9	

The table above show there is a significant difference on confidence levels between young counselors and older counselors. The older the counselor the more the confidence levels in performing specific counseling skills. For example, the mean score of 20-30 year old counselors is 2.850 compared to 3.0 score for counselors aged above 50 years and above with a p-value of 0.013.

The P-value on the sex deference was 0.124 and therefore not significant. The same was noted on qualification levels of counselors. The confidence level of counselors is not affected by level of education. The p-value was 0.0798 and therefore insignificant.

The work experience of counselors was also insignificant with a P-value of 0.409. On the type of clients attended between children, adolescent and adult, there was no significance difference in confidence levels with a p-value of 0.148. The same was noted on membership to professional bodies. There was no significant difference in confidence levels between counselors who are members of a professional body and those who are not members. The p- value was 0.810 and therefore not significant

4.7.2 Therapeutic approach used

Counselors who used psychodynamic and humanistic approach scored more at 2.987 and 3.0 on application of general counseling skills than those using other therapeutic approaches.

Table 32

		N	Mean	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum	P value
					Lower Bound	Upper Bound			
Part 1 mean score	Behavioral approach CBT	16	2.912	.1134	2.852	2.973	2.7	3.0	0.054
	Eclectic	11	2.964	.0458	2.933	2.994	2.9	3.0	
	Group therapy	9	2.985	.0444	2.951	3.019	2.9	3.0	
	Humanistic	5	2.987	.0298	2.950	3.024	2.9	3.0	
	Person Centered	17	2.890	.1353	2.821	2.960	2.6	3.0	
	Psychodynamic	5	3.000	.0000	3.000	3.000	3.0	3.0	
	Total	63	2.939	.1011	2.913	2.964	2.6	3.0	
Part 2 mean score	Behavioral approach CBT	17	2.947	.1328	2.879	3.015	2.6	3.0	0.563
	Eclectic	11	2.991	.0302	2.971	3.011	2.9	3.0	
	Group therapy	8	2.988	.0354	2.958	3.017	2.9	3.0	
	Humanistic	5	3.000	.0000	3.000	3.000	3.0	3.0	
	Person Centered	15	2.980	.0561	2.949	3.011	2.8	3.0	
	Psychodynamic	6	3.000	.0000	3.000	3.000	3.0	3.0	
	Total	62	2.977	.0777	2.958	2.997	2.6	3.0	
art 3 mean score	Behavioral approach CBT	15	2.883	.1750	2.786	2.980	2.5	3.0	0.581
	Eclectic	10	2.838	.2024	2.693	2.982	2.4	3.0	
	Group therapy	8	2.953	.1095	2.862	3.045	2.7	3.0	
	Humanistic	5	2.888	.1677	2.679	3.096	2.6	3.0	
	Person Centered	14	2.857	.1706	2.759	2.956	2.6	3.0	
	Psychodynamic	6	2.958	.0757	2.879	3.038	2.8	3.0	
	Total	58	2.887	.1624	2.844	2.930	2.4	3.0	

4.7.3 License to work as counselor?

Table 33 below show there was a significant deference between counselors who knew they did not require a license and those who though they required license to operate with a p-value of 0.054 Those who knew they did not require license to operate as counselors scored better on use of general counseling skills than those who thought they required licenses at 2.9826 and 2.864. The more they knew more about counseling environment and fact they did not require license to operate the better was their confidence levels.

The same was different on the use of specific skills in counseling with a score of 0.297 against 0.2906 among those who thought they required license. However, there was no significant difference on Part three with scores of 2.876 and 2.821 respectively and p-value of 0.238.

Table 33

Score on confidence levels		N	Mean	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum	P value
					Lower Bound	Upper Bound			
Part 1 mean score	No	47	2.928	.1310	2.889	2.966	2.5	3.0	0.049
	Yes	25	2.864	.1224	2.813	2.915	2.7	3.0	
	Total	72	2.906	.1308	2.875	2.936	2.5	3.0	
Part 2 mean score	No	43	2.979	.0675	2.958	3.000	2.7	3.0	0.012
	Yes	26	2.908	.1598	2.843	2.972	2.6	3.0	
	Total	69	2.952	.1158	2.924	2.980	2.6	3.0	
Part 3 mean score	No	44	2.876	.1894	2.819	2.934	2.4	3.0	0.238
	Yes	22	2.821	.1522	2.754	2.889	2.6	3.0	
	Total	66	2.858	.1787	2.814	2.902	2.4	3.0	

4.7.4 Licensing body

Counselor who believed they required city council licenses and Kenya counselors and psychologists licenses (KCPA) scored more at 2.933 on use of general counseling skills with p-value of 0.014. The p-value was therefore significant

Table 34

		N	Mean	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum	P value
					Lower Bound	Upper Bound			
Part 1 mean score	City council	3	2.933	.0000	2.933	2.933	2.9	2.9	0.014
	KAPC	2	2.900	.0471	2.476	3.324	2.9	2.9	
	KCA	4	2.683	.0333	2.630	2.736	2.7	2.7	
	KCPA	4	2.933	.0943	2.783	3.083	2.8	3.0	
	AG chambers	8	2.883	.1321	2.773	2.994	2.7	3.0	
	Total	21	2.863	.1273	2.806	2.921	2.7	3.0	
Part 2 mean score	City council	3	3.000	.0000	3.000	3.000	3.0	3.0	0.885
	KAPC	2	2.950	.0707	2.315	3.585	2.9	3.0	
	KCA	3	2.867	.2309	2.293	3.440	2.6	3.0	
	KCPA	5	2.920	.1789	2.698	3.142	2.6	3.0	
	AG chambers	7	2.914	.1574	2.769	3.060	2.6	3.0	
	Total	20	2.925	.1482	2.856	2.994	2.6	3.0	
Part 3 mean score	City council	2	2.906	.0442	2.509	3.303	2.9	2.9	0.230
	KAPC	1	2.875	.	.	.	2.9	2.9	
	KCA	4	2.734	.1795	2.449	3.020	2.6	3.0	
	KCPA	4	2.953	.0938	2.804	3.102	2.8	3.0	
	AG chambers	8	2.773	.1565	2.643	2.904	2.6	3.0	
	Total	19	2.822	.1549	2.748	2.897	2.6	3.0	

Chapter 5

DISCUSSION

5.1 DISCUSSION

The study found that the counselor's age and therapeutic approach was significant with a mean of 3.0 and p-value of 0.013. The older the counselor, the higher was the confidence levels. The competence levels measured by use of counseling skills among the counselors was found to be high indicating that most counselors were good at the application of general counseling skills but the same was noted to be low on dealing with some specific psychological conditions such as clients who are sexually attracted to the therapists (9.3%).

The qualifications and training of counseling providers is crucial to ensuring professionalism. The study found that many counselors were trained at local colleges and universities with Amani counseling and training institute leading the pack at 26% among individual institutions. The public universities offering counseling were only 2 compared to 14 private institutions offering the same. Majority of the counselors 36 (57.3%) had diploma level training. Those who had PhD training or masters are 14% and 1.3%. Counseling providers in many countries require certain professional training and academic qualification to be allowed to practice. In America, National Board for Certified Counselors (NBCC) certification program recognizes counselors who have met predetermined standards in their training, experience and performance on the National Counselor Examination for Licensure and Certification (Butler L. & Crago M. 1991).

On the type of counseling methods provided in these clinics, it was found that 23.7% use personal centered method followed by cognitive behavioral therapy (CBT), eclectic methods, psychodynamic, group therapy and humanistic therapy in that order. However, there was a significant difference in performance among those using humanistic and psychodynamic therapy with a p-value of 0.054

The study found that counseling clinics in Nairobi are allowed to operate by different bodies. On the registration or licenses for operating these clinics, 69.7% operate with no licenses. The study found there was no legal entity or procedure of giving licenses or accreditation to counselors or counseling institutions. Licenses in counseling in a number of countries are governed by various laws and regulated by different bodies. The overall objective of the legal and regulatory policy is to ensure that the needs and concerns of clients and patients are safeguarded, ethical and best practices are maintained. In America, the American Counseling Association (ACA) and the National Board for Certified Counselors (NBCC) and work together to further the profession of counseling; promotes quality counseling through certification and advances professional accountability and visibility in the United States.

The study established that 80% of the counselors belong to a professional counseling body with Kenya counselors and psychological association (KCPA) leading in this pack at 52.8%. However, there was no significant difference in confidence levels between counselors who are members of a professional body and those who are not members. The p- value was 0.810 and therefore not significant. Professional bodies regulate activities of certain professions and help to maintain ethical standard.

Counseling is a learning-oriented process, which occurs usually in a private and confidential interactive relationship, with the aim of helping a person learn more about the self, and to use such understanding to enable the person to become an effective member of society (Kanfer, FH & Goldstein A.P, 1986).The study found out centers located in town suffered from inadequate spacing and did not have a standard counseling room. A good counseling room should have ample space so as to ensure that the clients feel secure and there is complete confidentiality. About 15% of the centres were not a standalone facility and had other business unrelated to counseling running alongside it.

The Profession of counseling and psychotherapy requires people who can be able to provide clear diagnosis and treatment. The study found insufficient use of diagnostic tools among the counselors with 67% usage. Counselors use tests generally for assessment, placement, and guidance, as well as to assist clients to increase their self-knowledge, practice decision making, and acquire new behaviors. On the type of counseling provided, it was found out that general counseling was leading at 34% and HIV/VCT counseling at the bottom with 5.3%. With the use of life prolonging drugs by people living with HIV/Aids and reduction in HIV/Aids related deaths HIV/VCT counselors training and services appear to be on the decline compared to other types of counseling services.

Some of the challenges counselor's face in providing their services includes inadequate facilities and capacity building. Lack of professional development; comprises lack of measures to develop (personal growth) to become better counselors, poor remuneration and burnout were the main professional challenges. Burnout remains a major concern among many care givers. Lack of awareness among the populace on importance of counseling and lack of regulatory process makes it possible for anyone to claim to be a counselor. The weak enforcement of ethical standards and lack of acceptable accreditation system exposes both the counselor and clients to legal and ethical challenges. Kenya has experienced a period of policy positioning in line with the new constitution that encompasses democratic changes, health and human rights. These broad positions will impact on both public and private sector to improve quality and increase efficiency to transform the lives of people in all aspect, Wango G.M (2011),

5.2 SUMMARY OF FINDINGS

The objective of this study was to understand how counseling clinics operate in Nairobi. The Counselor's self efficacy scale was administered to understand the competence levels of counselors providing counseling service in Nairobi and is justifiable to conclude the following;

1. That there is no regulatory framework for operations of counseling clinics in Kenya and most clinics operating in Nairobi have no licenses.
2. There was no legal body to provide professional counseling licenses, enforce ethical standards, provide accreditation or recognition to counselors in Nairobi
3. The study found counseling services and training in Kenya to be more driven by the private sector and over two thirds of the clinics operating in Nairobi are operated by the private sector and NGOs.
4. The study found most counselors were confident in the application of general counseling skills
5. There was significance difference between old counselors and those that are young in chronological age. The older the counselor the more the confidence levels.
6. There was significant association between the counseling method used by counselors and confidence levels. Those using psychodynamic and personal centered method of counseling were more confident than others.
7. There was no significant difference between counselors who are members of professional association and those who are not.
8. Lack of awareness among the general population on importance of counseling and lack of legal counseling process are some of the major challenges facing counselor in Nairobi
9. The study found that the professional back ground of most counselors was in social work, nursing and teaching.

5.3 STUDY LIMITATION

At the AG's office, counseling providers were registered as Business names, companies, training institutions, partnerships and Association or health facilities and was therefore difficulty to get a consolidated list of counseling institutions from one source. Some details such as physical location or contact were also missing and those indicated not current as some had moved offices or changed contacts since their registration. The researcher had to find alternative ways of getting contacts from counseling/psychological associations and the internet and this process took some time.

5.4 CONCLUSION

The study found that counseling services in Kenya are not regulated by any regulatory framework and this exposes both the counselor and the clients to legal and professional challenges. Counseling would be more enhanced and attract qualified personnel if it is well regulated and follow the legal and internationally accepted best practices. The counseling professional bodies have a role to play in regulating its members and ensure ethical standards are maintained. The public need to be sensitized on the benefits of counseling to make them understand and embrace counseling services.

5.5 RECOMMENDATIONS

From the above findings, it is imperative to highlight a few recommendations so as to improve the provision of counseling services in Kenya.

1. There is need for legal framework to regulate the establishment of counseling services. The framework should provide for a regulatory body to regulate counseling services and enforce compliant.

2. The counseling professional bodies should play an active role in the development and supervision of counselors to ensure best practices.

3. There is need for minimum level of training for one to become a counseling practitioner and a minimum training standard.

5.6 FURTHER RESEARCH

Further research should be done to establish effectiveness of professional counseling bodies in relation to supervision of counselors and maintenance of best practice. The relationship, networking and referral systems among counselors which was found to exist especially at the district (county) and divisional levels should be subjected to further research to measure its impact and areas that would require improvement

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APPENDIX I

CONSENT FORM

Informed consent explanation

Counseling has become an important mental health service in Kenya today. Stephen Wahome wishes to carry out a study titled "*a study on the regulatory frameworks and operation of counseling clinics in Nairobi city"*. The purpose of this study is to establish how counseling clinics operate in Nairobi under the direction of Dr. D. Kathuku and Dr. Anne Obondo, department of Psychiatry, University of Nairobi.

You are expected to understand the following;

That your agreement to participant in this study is voluntary

You will not receive any token or monetary benefit by participating in the study

You may withdraw from the study at anytime

Refusal to participate will not lead to any penalty or loss of benefit to which you are entitled

After reading the explanation, please feel free to ask any questions that will allow you to understand the nature of this study.

The procedure will involve a request to fill in a questionnaire. No invasive procedures such as drawing of blood will be involved.

All information obtained from this study will remain confidential and your privacy will be upheld. No names will be used in this study and future publications, identification will be by serial number. The information will be used for the purpose of this study alone.

You benefit by participating in this research by knowing that you have proudly contributed in helping gain knowledge about counseling services in Nairobi.

CONSENT DECLARATION

I_____ do hereby consent to participate in this study entitled *"a study on the regulatory frameworks and operation of counseling clinics in Nairobi city"*. I fully understand the nature and purpose of this study as it was well explained to me

Signed _____ **Serial Number** _____

Witness Name_____ **signature**_____

Researcher Contact

STEPHEN WAHOME
Clinical Psychologist,
P.O. Box 8160-00300 Nairobi.

Signed_____ Date_____

Ethics Research Committee contact

KNH/UON-ERC Secretary
Email; uonknh_erc@uonbi.ac.ke

APPENDIX II

COUNSELOR ACTIVITY SELF-EFFICACY SCALE

General Instructions; The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counsellor behaviors or to deal with particular issues in counseling. Please provide your honest, candid responses that reflect your belief about your current capabilities, rather than how you would like to be seen or how you might look in the future. There is no right or wrong answers to the following questions. Using a dark pen or pencil, please circle the number that best reflects your responses to each question

Part I

Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling most clients.

No Confidence			Some confidence			Complete Confident			
0	1	2	3	4	5	6	7	8	9

How confident are you that you could use these general skills effectively with most clients over the next week?

1.	**Attending** (orient yourself physically towards the client)	0 1 2 3 4 5 6 7 8 9
2.	**Listening** (capture and understand the messages that clients Communicate)	0 1 2 3 4 5 6 7 8 9
3.	**Restatements** (repeat or rephrase what the client has said, in a way that is succinct, concrete and clear)	0 1 2 3 4 5 6 7 8 9
4.	**Open questions** (ask questions that help clients to clarify or explore their thoughts or feelings)	0 1 2 3 4 5 6 7 8 9
5.	**Reflection** of feelings (repeat or rephrase the client's statements with an emphasis on his or her feelings).	0 1 2 3 4 5 6 7 8 9
6.	**Self-disclosure** for exploration (reveal personal information about your history, credentials or feelings)	0 1 2 3 4 5 6 7 8 9
7.	**Intentional silence** (use silence to allow clients to get in touch with their thoughts or feelings)	0 1 2 3 4 5 6 7 8 9
8.	**Challenges** (point out discrepancies, contradictions defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change)	0 1 2 3 4 5 6 7 8 9
9.	**Interpretations** (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behaviour, thoughts, or feelings)	0 1 2 3 4 5 6 7 8 9
10.	**Self-disclosures for insight** (disclose *past* experiences in which you gained some personal insight)	0 1 2 3 4 5 6 7 8 9
11.	**Immediacy** (disclose *immediate* feelings you have about the client, the therapeutic relationship, or yourself in relation to the client)	0 1 2 3 4 5 6 7 8 9
12.	**Information-giving** (teach or provide the client with data, opinions, facts, resources, or answers to questions)	0 1 2 3 4 5 6 7 8 9

13. **Direct guidance** (give the client suggestions, directives, or advice that imply actions for the client to take). 0 1 2 3 4 5 6 7 8 9

14. **Role-play and behavior rehearsal** (assist the client to role-play or rehearse behavior in-session) 0 1 2 3 4 5 6 7 8 9

15. **Homework** (develop and prescribe therapeutic assignments for clients to try out between sessions) 0 1 2 3 4 5 6 7 8 9

Part II.

Instructions: Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients.

No Confidence			Some confidence			Complete Confident			
0	1	2	3	4	5	6	7	8	9

How confident are you that you could do these specific tasks effectively with most clients over the next week?

1. Keep sessions "on track" and focused. 0 1 2 3 4 5 6 7 8 9

2. Respond with the best helping skill, depending on what your client needs at a given moment. 0 1 2 3 4 5 6 7 8 9

3. Help your client to explore his or her thoughts, feelings and actions. 0 1 2 3 4 5 6 7 8 9

4. Help your client to talk about his or her concerns at a "deep" level. 0 1 2 3 4 5 6 7 8 9

5. Know what to do or say next after your clients talks. 0 1 2 3 4 5 6 7 8 9

6. Help your client set realistic counseling goals. 0 1 2 3 4 5 6 7 8 9

7. Help your client to understand his or her thoughts, feelings and actions. 0 1 2 3 4 5 6 7 8 9

8. Build a clear conceptualization of your client and his or her counseling issues. 0 1 2 3 4 5 6 7 8 9

9. Remain aware of your intentions (i.e., the purpose of your interventions)during sessions. 0 1 2 3 4 5 6 7 8 9

10. Help your client to decide what actions to take regarding his or her problems. 0 1 2 3 4 5 6 7 8 9

Part III

Instructions: Please indicate how confident you are in your ability to work effectively, over the next week with each of the following client types, issues, or scenarios (By "work effectively", I am referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions, and, ultimately, to help the client resolve his or her issues.

No Confidence Some confidence Complete Confident
0 1 2 3 4 5 6 7 8 9

How confident are you that you could work effectively over the next week with a client who…

1.	Is clinically depressed .	0	1	2	3	4	5	6	7	8	9	
2.	Has been sexually abused	0	1	2	3	4	5	6	7	8	9	
3.	Is suicidal	0	1	2	3	4	5	6	7	8	9	
4.	Has experienced a recent traumatic life event (e.g. physical or psychological injury or abuse)	0	1	2	3	4	5	6	7	8	9	
5.	Is extremely anxious	0	1	2	3	4	5	6	7	8	9	
6.	Shows signs of severely disturbed thinking	0	1	2	3	4	5	6	7	8	9	
7.	You find sexually attractive	0	1	2	3	4	5	6	7	8	9	
8.	Is dealing with issues that you personally find difficult to handle	0	1	2	3	4	5	6	7	8	9	
9.	Has core values or beliefs that conflict with your own (e.g, regarding religion, gender role),	0	1	2	3	4	5	6	7	8	9	
10.	Differs from you in a major way or ways (e.g. race, ethnicity, gender, age, social economic status)	0	1	2	3	4	5	6	7	8	9	
11.	Is not "psychologically-minded" or introspective	0	1	2	3	4	5	6	7	8	9	
12.	Is sexually attracted to you.	0	1	2	3	4	5	6	7	8	9	
13.	You have negative reactions toward (e.g, boredom, annoyance)	0	1	2	3	4	5	6	7	8	9	
14.	Is at an impasse in therapy	0	1	2	3	4	5	6	7	8	9	
15.	Wants more from you that you are willing to give (e.g in terms of frequency of contacts or problem-solving prescriptions)	0	1	2	3	4	5	6	7	8	9	
16.	Demonstrates manipulative behaviors in-session.	0	1	2	3	4	5	6	7	8	9	

Note: Adapted from instrument whose responses were analyzed and presented in R. W. Lent, C. E. Hill and M. A. Hoffman, "Development and Validation of the Counselor Activity Self-Efficacy Scales," 2003, *Journal of Counseling Psychology*, 50, pp. 97-108; the survey instrument itself, which was not published in the article, is copyrighted by the lead author, ©2003 by R. W. Lent. Adapted with permission.

APPENDIX III

QUESTIONNAIRE

a) General questionnaire for counseling services providers

This questionnaire is aimed at understanding the operations of counseling clinic in Nairobi and their needs. This study targets selected institutions, organizations and counseling facilities, Stephen Wahome, from University of Nairobi, Psychiatry Department is conducting this study. You are requested to respond to the questions below faithfully and honestly. The findings of this research are intended to inform on the regulatory frameworks and provide feedback on operations of counseling clinics in Nairobi. Confidentiality of the information given will be guaranteed.

Please fill in the blanks and tick accordingly

1 Type of Institution / Organization

- ☐ Non- Governmental Organization (NGO)
- ☐ Faith Based Organization (FBO)
- ☐ Community Based Organization (CBO)
- ☐ Public Institution
- ☐ Private entities
- ☐ Others (specify)

2. How long has your organization been in operation?

☐ 1 – 5 Years ☐ 6 – 10 Years ☐ 11- 15 Years
☐ 16- 20 Years ☐ 21 and above

3 Name of the Organization/Institution, physical contact and location

4 What services do you provide?

- ☐ Health
- ☐ Social
- ☐ Environmental Services
- ☐ Propagation of faith
- ☐ Sensitization
- ☐ Youth
- ☐ Legal
- ☐ Others please specify
- ☐ Education
- ☐ Income Generation
- ☐ Gender
- ☐ Counseling
- ☐ HIV and AIDS
- ☐ Women ☐ Elderly
- ☐ Relief and support

5 Do you offer Counseling in your organization? Yes ☐ No ☐

6 Do you offer Counseling training in your organization? Yes ☐ No ☐

7 State the period you been offering counseling services Years ☐ months ☐

8 Did you require any license or permission to operate a counseling facility? Yes ☐ No ☐

9 State the institution or body that provided you the licenses or permission to operate_____

10 State two conditions that you had to fulfill to obtain your license1_____
2_____

11 How many Counselors provide counseling at your clinic?

- Full time staff._____ Part- time staff_____
- Volunteers_____ Student/attachment_____

12 Indicate the number of counselor who had the following occupations as their previous career

☐ Teachers ☐ Nurses ☐ Law enforcement ☐ others (specify)
☐ Doctor's ☐ Social workers ☐ religious _____
☐ Business ☐ Lawyers ☐ politicians

13 Indicate the number of counselors with the following counseling qualifications in your institution.

☐ Certificate ☐ Diploma
☐ Bachelor ☐ Masters ☐ PhD

14 Is there any counseling network in your area? Yes ☐ N0 ☐

a. If yes at what level

☐ Village ☐ Ward
☐ Division ☐ District
☐ Regional ☐ National
☐ International

15 How is counseling services funded or paid for

☐ Clients / patients ☐ referring agencies
☐ Budget ☐ Government
☐ Local donor's ☐ National agencies
☐ International agencies ☐ others

16 What is the range of your consultation fee

☐ Above Kshs 5000 ☐ Kshs 500- 1000 Free ☐
☐ Kshs1000-1500 ☐ Kshs 1500-2000
☐ Kshs 2000-2500 ☐ Kshs2500-3000
☐ Kshs 3000-4000 ☐ above Kshs 4000

17 Who are your target clients?

_____

18 State the main body/institution that has registered your clinic _____

19 What type of counseling method is used in your counseling clinic_____?

2. INTERVIEW SCHEDULE FOR COUNSELORS

Interview Schedule for Counselors

This interview is aimed at understanding the operations of counseling clinic in Nairobi and their needs. This study targets selected institutions, organizations and counseling facilities, Stephen Wahome, from University of Nairobi, Psychiatry Department is conducting this study. You are requested to respond to the questions below faithfully and honestly. The findings of this research are intended to inform the implementation of an operational framework, provide feedback on operations and how to improve counseling services in Nairobi. Confidentiality of the information given will be guaranteed.

Personal Data:

Age: Between: 20-30 years ☐ 31-40 years ☐ 41-50years ☐ above 50 ☐

SEX: Female**:** ☐ Male**:** ☐

Marital status: Single: ☐ Married: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐

Education Level: Secondary school ☐ Undergraduate: ☐ Post –Graduate: ☐

Employment status employed ☐ self employed ☐ unemployed ☐

1. How many years have worked as a counsellor? _____.

2. In which institution did you train as a counselor_____.
   a) How long did the counseling training take_____
   b) What qualification were you awarded_____?

3. How many clients/patients do you counsel?
   a. Daily_____
   b. Weekly_____
   c. Monthly_____
   d. Quarterly/term/semester_____
   e. Annually_____

4. Before you became a counselor what was your professional background? _____
   a. On what level? _____
   b. For how long_____

5. What is your highest professional qualification?
   Certificate ☐ Diploma☐
   Bachelor ☐ Master ☐ PhD ☐

7. Is counseling your primary job? Yes☐ No ☐ If no, which other jobs do you do_____

8. What type of clients do you attend to; Children ☐ Adolescent ☐ Adults ☐ all☐

9. Do you receive any supervision?
   a. From personal therapists?_____
   b. From peer Counselors?_____
   c. From supervisors?_____
   d. How often?_____

10. What is your institutional/ organizational procedure in offering counseling services?
    a) Do you have a referral system in place _____
    b) How do you network with your colleagues? _____

11. What challenges do you face in your work as a counsellor?

a. Resources_____

b. Professional_____

15. Are you a member of any professional counseling body? ____If yes which one_____

16. Do you receive any supervision from your professional bodies? Yes ☐ No ☐

17. List down most frequent counseling issues brought by males and females in your clinic

Males a)_____ b)_____ c)_____

Females a)_____ b)_____ c)_____

18. Did you require any type of license to operate as a counselor? Yes ☐ No ☐
If yes, where do you get it from _____How long does it last _____

19. What type of therapeutic approach/ method of counseling do you often use? _____

20 What type of counseling do you provide? _____

21 What type of screening /testing tools do you use in counseling? _____

22 What type of psychological tests do you conduct?_____

23. State the body/institution that accredited you as a counsellor_____

24 What is your comment about counseling services in Nairobi _____

_____